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Senate

The Senate met at 2 p.m. and was called to order by the President pro tempore (Mr. STEVENS).

The PRESIDENT pro tempore. Today's prayer will be offered by our guest Chaplain, the Reverend Greg St. Cyr, of the Bay Area Community Church in Annapolis, MD.

PRAYER

The guest Chaplain offered the following prayer:

Let us pray together.

God, I thank You for these men and women whom You have raised up to lead our Nation. Thank You for Your grace in their lives, for their gifts, for their talents, for their individual backgrounds, for their families, and for the States they represent. We acknowledge You as the Author and Sustainer of life. You are the God who holds us in the palm of Your hand, whose eye is always upon us, whose love is always with us.

We come before You now in need of You. You know all things. You know the present challenges we face, and You are intimately aware of our future. When King Solomon was newly crowned, he prayed to You asking that You would ''Give Your servant an understanding heart to judge Your people to discern good and evil (1 Kings 3:9).'' That request was pleasing in Your sight and You blessed him with wisdom. We come with a similar prayer.

Grant us supernatural wisdom to accomplish Your will and vision for our Nation this day. I pray Your blessing on each Senator, that they would have an understanding heart of wisdom to serve Your purposes today. Grant them godly leadership, wisdom, and courage. I ask this prayer in the name of Jesus Christ. Amen.

PLEDGE OF ALLEGIANCE

The PRESIDENT pro tempore led the Pledge of Allegiance, as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

RECOGNITION OF THE MAJORITY LEADER

The PRESIDING OFFICER (Mr. ROBERTS). The distinguished majority leader is recognized.

SCHEDULE

Mr. FRIST. Mr. President, today the Senate will immediately resume consideration of S. 1, the prescription drug benefits bill. We currently have 15 pending amendments from last week. As I have stated, these amendments are being reviewed, and we will begin the process of scheduling votes, as necessary, on some of these amendments. As previously announced, we will have a vote at 5:30 this evening on an amendment to S. 1. We will alert all Members shortly as to which of those amendments that will be. The managers will be discussing that shortly.

A number of Members have indicated they will be prepared to offer additional amendments during today's session. The two managers will be working with those Senators to set aside the pending amendments in order to consider further amendments over the course of the day. I am very pleased with what we accomplished last week, including last Friday, at which time we had a productive day in the offering and initial discussion of these amendments.

As we previously said, we will plan on completing action on this bill this week before the recess. We will have full days and, I am sure, late nights with votes until we complete action on this bill. We will complete this historic legislation prior to adjourning for the July Fourth recess. I do encourage all Members to prepare themselves for what will be a very busy and productive week. I do thank all Members in advance for their assistance this week and in participating with the managers to bring this bill to closure.

RESERVATION OF LEADER TIME

The PRESIDING OFFICER. Under the previous order, the leadership time is reserved.

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003

The PRESIDING OFFICER. Under the previous order, the Senate will resume consideration of S. 1, which the clerk will report.

The assistant legislative clerk read as follows:

A bill (S. 1) to amend title XVIII of the Social Security Act to make improvements in the medicare program, to provide prescription drug coverage under the medicare program, and for other purposes.

Pending:

Bingaman amendment No. 933, to eliminate the application of an asset test for purposes of eligibility for premium and cost-sharing subsidies for low-income beneficiaries.

Graham (FL) amendment No. 956, to provide that an eligible beneficiary is not responsible for paying the applicable percent of the monthly national average premium while the beneficiary is in the coverage gap and to sunset the bill.

Kerry amendment No. 958, to increase the availability of discounted prescription drugs.

Lincoln modified amendment No. 934, to ensure coverage for syringes for the administration of insulin, and necessary medical supplies associated with the administration of insulin.

Lincoln amendment No. 935, to clarify the intent of Congress regarding an exception to the initial residency period for geriatric residency or fellowship programs.

Lincoln amendment No. 959, to establish a demonstration project for direct access to physical therapy services under the Medicare Program.

Baucus (for Jeffords) amendment No. 964, to include coverage for tobacco cessation products.

Baucus (for Jeffords) amendment No. 965, to establish a Council for Technology and Innovation.

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

Nelson (FL) amendment No. 938, to provide for a study and report on the propagation of concierge care.

Nelson (FL) amendment No. 936, to provide for an extension of the demonstration for ESRD managed care.

Baucus (for Harkin) amendment No. 967, to provide improved payment for certain mammography services.

Baucus (for Harkin) amendment No. 968, to restore reimbursement for total body orthotic management for nonambulatory, severely disabled nursing home residents.

Baucus (for Dodd) amendment No. 969, to permit continuous open enrollment and disenrollment in Medicare Prescription Drug plans and MedicareAdvantage plans until 2008.

Baucus (for Dodd) amendment No. 970, to provide 50 percent cost-sharing for a beneficiary whose income is at least 160 percent but not more than 250 percent of the poverty line after the beneficiary has reached the initial coverage gap and before the beneficiary has reached the annual out-of-pocket limit.

Baucus (for Cantwell) amendment No. 942, to prohibit an eligible entity offering a Medicare Prescription Drug plan, a MedicareAdvantage Organization offering a Medicare Advantage plan, and other health plans from contracting with a pharmacy benefit manager (PBM) unless the PBM satisfies certain requirements.

The PRESIDING OFFICER. The distinguished Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, I see the Senator from West Virginia is in the Chamber.

Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the pending amendments be temporarily laid aside so the Senator from West Virginia can offer his amendments.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The distinguished Senator from West Virginia is recognized.

AMENDMENTS NOS. 975 AND 976

Mr. ROCKEFELLER. Mr. President, before offering my amendments, I am going to discuss both of them because they are being reviewed, at this point, in the majority cloakroom. But I am going to be offering two amendments this afternoon in order.

The first amendment I will offer is to ensure that all Medicare beneficiaries will be eligible for this new drug benefit, including low-income Medicare beneficiaries who are currently eligible for Medicaid and Medicare. They are known as dual eligibles.

The underlying bill precludes Medicare beneficiaries—makes it impossible for Medicare beneficiaries—who are eligible to receive a drug benefit through Medicaid from, in fact, enrolling in the Medicare drug benefit program.

This group is referred to as the dual-eligible group. They are the poorest seniors under Medicare. They are below 74 percent of poverty. That is their income level. A disproportionate share of them—to wit, 42 percent—are minorities. Women make up the majority of them all. Many are likely to have a poor education, live alone, and have more than two chronic illnesses.

The underlying bill precludes these folks that I have just talked about—these duel-eligible beneficiaries—from receiving the Medicare drug benefit. As a result, this prescription drug benefit is not, in fact, at all a universal bill. Now, that is important in a lot of ways. One is philosophical and the other is extremely practical.

The philosophical one is that in 1965, when we created Medicare, it was created as a universal benefit to all who qualify. It was the promise that society made to our seniors: That if you work, if you make your payroll contributions, then you, at the proper time, qualify for Medicare regardless of where you live, regardless of how old you might be, or your income.

As I have noted before, the underlying legislation, for the first time in the history of the Medicare Program, would prohibit some Medicare beneficiaries from receiving a Medicare benefit.

My amendment would make the Medicare prescription drug benefit a universal benefit by adopting the provisions that were, in fact, contained in the tripartisan proposal introduced last summer.

It would eliminate the exclusion of Medicaid beneficiaries and make the new Medicare Part D drug benefit—that is the new part we are creating—available to all Medicare beneficiaries regardless of income. Medicaid would be the secondary payer for Medicare beneficiaries eligible for Medicaid wrapping around this new Part D drug benefit and its low-income protections.

Again, this is exactly the same construction the majority of my Republican colleagues supported in the Grassley-Snowe-Hatch-Jeffords-Breaux Medicare bill that was voted on by the full Senate last summer. The National Governors Association sent a letter to Chairman GRASSLEY and Senator BAUCUS which said the following about the exclusion of some of these seniors, that is, the dual-eligible seniors, those at 74 percent or below the poverty level, from Medicare:

> The nation's Governors oppose this approach. It is not good health policy. It is not good precedent. A major reason that States currently have a long-run structural problem in their fiscal outlook is that they have absorbed responsibility for dual eligibles.

They go on to say:

> This provision will continue to shift appropriate federal costs to the states.

Governors Patton of Kentucky and Kempthorne of Idaho went on to say:

> If the dual eligible populations continue to be a joint responsibility, states will be forced to cut the optional (Medicaid) benefits and populations—mostly women and children—which are a key investment in the future.

The President agrees. In a speech he recently gave on Medicare, he said:

> And all low-income seniors should receive extra help so that all seniors will have the ability to choose a Medicare option that includes a prescription drug benefit.

The Medicare prescription drug legislation being considered by the House of Representatives would shift the entire drug bill to Medicare. It is not on a frequent day that Chairman THOMAS and I are in full agreement. But he does say such a shift ''ensures that all seniors across the country will have access to affordable prescription drugs, while alleviating much of the burden that states now confront.'' I say to my colleagues, as I indicate, I am not always in agreement, but we are going forward directly together on this policy, I hope.

The current system is uncoordinated and sometimes conflicting in terms of coverage policies. It actually creates worse health outcomes for people on both Medicaid and Medicare, either one. Fully integrating a key benefit for prescription drugs into Medicare is a critical first step toward improving the current system's flaws.

It needs to be clearly understood by my colleagues that Medicaid in the hands of Governors, which I had the honor of being at one point, is subject to whatever their whims might be. It is subject to budget pressures. Remember, they have to balance the budget. We don't; they do. And they frequently do it on the backs of Medicaid beneficiaries—that is, that part of these Medicare-Medicaid dual eligibles—so they can increase the number of prescription drugs which are available under Medicaid in their State. They can change it in many ways because the programs vary widely. Not only is it unfair to exclude the poorest seniors from part of the Medicare program, it is a raw deal for some of our neediest seniors.

Prescription drugs are, as I said, an optional benefit under Medicaid. States can and do limit the number of prescriptions. Some States only cover three drugs or they could charge any copayments they want. Remember, what we are looking at here is a group of people who are below 74 percent of poverty which is clearly in single-digit gross income. So the patchwork of the benefits varies tremendously from State to State. For seniors who have worked all their lives, paid into the Medicare system, it is not fair for them to be at the mercy of State coverage decisions.

If you look around the country right now, the fastest growing expense of any State is Medicaid, part of this dual-eligible conundurm, and those programs are being cut. You can see it, read about it, and hear about it. So it is highly volatile, and it is not safe health care policy.

Medicare has failed in its efforts to provide comprehensive prescription drug coverage to seniors ever since the

repeal of the Medicare Catastrophic Act in 1988. Virtually all advances in drug coverage for seniors since then have been delivered not by us but by the States. While at the same time the States have been cutting back in recent years, they have also made improvements. We have done nothing. They have done whatever has been done.

Without some long-term restructuring of the State-Federal partnership for this population, this dual-eligible, 74-percent-of-poverty-minus population, much of the advances the States have made will be lost. All Medicare beneficiaries deserve to receive Medicare benefits. There should be no exceptions for drugs. It would be very bad precedent to make Medicaid pay for items that are clearly the responsibility of Medicare except at the present and in this bill for one particular discrete population.

The intention is for this amendment to be budget neutral. I would like to say it is budget neutral, but I cannot in that I asked CBO for a cost estimate last week and I do not yet have one.

This is a concern and an agony shared by many. Once we have this estimate, we will either conclude that we can go ahead because we will know it is budget neutral or I will be happy to work with the chairman and ranking member on appropriate offsets.

I urge my colleagues to provide all the seniors in their States with the benefit of real Medicaid drug benefit by supporting this amendment.

I will at the appropriate time ask that it be acted upon. I am awaiting a particular series of sheets of paper but in the meantime, in the minute or so that will require, I send to the desk an amendment and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from West Virginia [Mr. ROCKEFELLER], for himself, Ms. MIKULSKI, and Mrs. CLINTON, proposes an amendment numbered 975.

The amendment is as follows:

(Purpose: To make all Medicare beneficiaries eligible for Medicare prescription drug coverage)

On page 10, lines 12 and 13, strike ''(other than a dual eligible individual, as defined in section 1860D–19(a)(4)(E))''.

On page 21, strike lines 22 through 25, and insert ''title XIX through a waiver under 1115 where covered outpatient drugs are the sole medical assistance benefit.

On page 107, line 3, strike ''30 percent'' and insert ''27.5 percent''.

On page 116, line 10, insert ''and'' after the semi-colon.

On page 116, line 12, strike ''; and'' and insert a period.

On page 116, strike lines 13 through 17.

On page 116, line 24, insert ''and'' after the semi-colon.

On page 117, line 2, strike ''; and'' and insert a period.

On page 117, strike lines 3 through 7.

On page 117, line 13, insert ''and'' after the semicolon.

On page 117, line 17, strike ''; and'' and insert a period.

On page 117, strike lines 18 through 23.

On page 118, line 6, insert ''and'' after the semicolon.

On page 118, in line 13, insert ''or'' after the semi-colon.

On page 118, line 14, strike ''; or'' and insert a period.

On page 118, strike line 15.

Beginning on page 118, strike line 16 and all that follows through page 119, line 9.

On page 119, line 10, strike ''(F)'' and insert ''(E)''.

On page 119, line 15, strike ''(G)'' and insert ''(F)''.

On page 119, line 19, strike ''(C), (D), or (E)'' and insert ''(C), or (D)''.

On page 120, line 3, strike ''(H)'' and insert ''(G)''.

On page 120, lines 5 and 6, strike ''who is a dual eligible individual or an individual''.

Beginning on page 121, line 24, strike ''dual eligible'' and all that follows through ''and'' on page 122, line 1.

On page 146, line 6, insert before the period ''and to the design, development, acquisition or installation of improved data systems necessary to track prescription drug spending for purposes of implementing section 1935(c)''.

Beginning on page 146, strike line 23 and all that follows through page 149, line 21, and insert the following:

''(c) FEDERAL ASSUMPTION OF MEDICAID PRESCRIPTION DRUG COSTS FOR DUALLY ELIGIBLE BENEFICIARIES.—

''(1) IN GENERAL.—For purpose of section 1903(a)(1) for a State for a calendar quarter in a year (beginning with 2006) the amount computed under this subsection is equal to the product of the following:

''(A) STANDARD PRESCRIPTION DRUG COVERAGE UNDER MEDICARE.—With respect to individuals who are residents of the State, who are entitled to, or enrolled for, benefits under part A of title XVIII, or are enrolled under part B of title XVIII and are receiving medical assistance under subparagraph (A)(i), (A)(ii), or (C) of section 1902(a)(10) (or as the result of the application of section 1902(f)) that includes covered outpatient drugs (as defined for purposes of section 1927) under the State plan under this title (including such a plan operated under a waiver under section 1115)—

''(i) the total amounts attributable to such individuals in the quarter under section 1860D–19 (relating to premium and cost-sharing subsidies for low-income medicare beneficiaries); and

''(ii) the actuarial value of standard prescription drug coverage (as determined under section 1860D–6(f)) provided to such individuals in the quarter.

''(B) STATE MATCHING RATE.—A proportion computed by subtracting from 100 percent the Federal medical assistance percentage (as defined in section 1905(b)) applicable to the State and the quarter.

''(C) PHASE-OUT PROPORTION.—Subject to subparagraph (D), the phase-out proportion for a quarter in—

''(i) 2006 is 95 percent;

''(ii) 2007 is 90 percent;

''(iii) 2008 is 85 percent;

''(iv) 2009 is 80 percent;

''(v) 2010 is 75 percent; or

''(vi) 2011, 2012 and 2013 is 70 percent.

''(d) MEDICAID AS SECONDARY PAYOR.—In the case of an individual who is entitled to a Medicare Prescription Drug plan under part D or drug coverage under a MedicareAdvantage plan, and medical assistance including covered outpatient drugs under this title, medical assistance shall continue to be provided under this title for covered outpatient drugs to the extent payment is not made under the Medicare Prescription Drug plan or a MedicareAdvantage plan.

Beginning on page 152, strike line 3 and all that follows through page 153, line 15, and insert the following:

''(f) DEFINITION.—For purposes of this section, the term 'subsidy-eligible individual' has the meaning given that term in subparagraph (D) of section 1860D–19(a)(4).''.

(C) CONFORMING AMENDMENTS.—

(1) Section 1903(a)(1) (42 U.S.C. 1396a(a)(1)) is amended by inserting before the semicolon the following: '', reduced by the amount computed under section 1935(c)(1) for the State and the quarter''.

(2) Section 1108(f) (42 U.S.C. 1308(f)) is amended by inserting ''and section 1935(e)(1)(B)'' after ''Subject to subsection (g)''.

Beginning on page 157, strike line 21 and all that follows through page 158, line 4.

On page 173, beginning on line 15, strike ''that is not'' and all that follows through ''includes'' on line 18 on that page, and insert ''that includes but is limited solely to''.

On page 190, in line 18, strike ''and''.

On page 190, between lines 18 and 19, insert the following:

''(B) is not a dual eligible beneficiary as defined under section 1807(i)(1)(B); and''.

On page 190, line 19, strike ''(B)'' and insert ''(C)''.

Mr. ROCKEFELLER. Mr. President, I also have the amendment for which I just spoke. I ask unanimous consent that that be brought to the desk for its consideration and the pending amendment be set aside.

The PRESIDING OFFICER. Is there objection to setting aside the amendment?

Mr. GRASSLEY. Reserving the right to object, and I shall not object, I would like to remind the Members of my caucus we do have an arrangement between the two parties that every other amendment offered could be offered by a Republican and then in turn by a Democrat. We have several Democrat amendments pending. There is nothing wrong with that. It hasn't hurt the process at all. But I think it would be fair for me to remind the Members of the Republican caucus if they have amendments to propose, come over and do it. It will speed up the process and I think be considered a little more fair by everybody here. I will not object.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report the amendment.

The assistant legislative clerk read as follows:

The Senator from West Virginia [Mr. ROCKEFELLER], for himself, Mr. CARPER, Mr. GRAHAM of Florida, Ms. MIKULSKI, Mrs. CLINTON, and Mr. DODD, proposes an amendment numbered 976.

Mr. ROCKEFELLER. Mr. President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To treat costs for covered drugs as incurred costs without regard to whether the individual or another person, including a State program or other third-party coverage, has paid for such costs)

On page 51, strike lines 15 through 25 and insert the following:

''(ii) such costs shall be treated as incurred without regard to whether the individual or another person, including a State program or other third-party coverage, has paid for such costs.

Mr. ROCKEFELLER. Mr. President, I wish to proceed with the amendment I was going to offer first but which will be my second amendment. That also will await the decision of the leadership.

Mr. President, I come to the floor again to offer an amendment that will ensure that contributions made on a beneficiary's behalf by their former employers count toward that beneficiary meeting the catastrophic limit. Let me just say, as I begin this, in our Finance Committee deliberations, it was this amendment which caused more stir, more angst, more sense of, oh, my heavens, we have not really done this, have we? We could not have made this mistake involving this many people. The amendment was handled in Finance—without success, from my point of view. Nevertheless, I was urged by colleagues on both sides of the aisle to bring this amendment to the floor because it has enormous implications. That will become apparent, hopefully, as I complete my statement.

This amendment is needed to protect the existing coverage of literally millions and millions of retirees who have earned drug coverage through their employer. That means they have been employed much of their lives by their employer and they have now retired and they are Medicare beneficiaries and the employer gave retiree benefits. We are accustomed to this in chemical, steel, and many other industries. But there is a problem that has arisen.

As much as we want to provide a new drug benefit for these seniors, we should not disrupt the basically foundational employer-provided drug coverage so many seniors have today. It is the largest source of drug coverage in the country and it is an honorable and a good one. It would be a very great mistake for my colleagues to walk away from this system and one that we would all very much regret.

Mr. President, in saying that employer-sponsored retiree health benefits are the largest single source of coverage for retirees, I simply say that one in every three Medicare beneficiaries is affected by the amendment I am now discussing. They will either lose their coverage or they will not, depending upon how this amendment is disposed.

Drug costs constitute 40 to 60 percent of employers' retiree health care costs. That is a lot. And steep price increases are prompting employers to, one, eliminate drug benefits in some circumstances; secondly, cap their contributions; thirdly, drop retiree coverage altogether. We all know this is a phenomenon of American life that has been going on in recent years.

Employers need immediate relief for their retiree prescription drug costs. A Medicare prescription drug benefit should relieve some of the burden on employers by covering a retiree's cost after a certain catastrophic limit. I recognize this gets technical, but it is profound. Instead, this benefit extends the amount of time before a retiree reaches that catastrophic benefit of about $4,000 by not being able to count as the employee's contribution—in fact, the employer's contribution toward that end is very substantial. Therefore, the employer receives no real relief from this benefit and is forced to drop the coverage they currently provide their retirees, leaving Medicare to pay the entire cost.

I think I do not have to explain that that means the Federal Government has to pick up even more of the cost of Medicare and prescription drugs than would otherwise be the case, for example, if this amendment were to pass.

The bill we are considering on the floor today exacerbates the current downward trend in retiree benefits by extending the amount of time the beneficiary relies on the employer before reaching the catastrophic limit. What does that say? It says if you extend the amount of time the employee has to keep paying and paying toward his catastrophic limit for a much longer time, there is therefore much more out-of-pocket costs to the employee.

This legislation discriminates against Medicare beneficiaries with employer-provided coverage with a trick definition—that is what is used—of out-of-pocket costs known, uninterestingly, as the ''true'' out-of-pocket costs. This plan would not allow any spending by employers to count toward meeting the catastrophic limit. In this way, the underlying legislation limits the overall spending by the Medicare Program at the expense of employers who offer retiree coverage.

The result is CBO estimates, as I indicated, that 37 percent of beneficiaries currently receiving a drug benefit from their employee will lose that coverage. Additionally, it extends the amount of time, as I have indicated, a beneficiary has to reach the catastrophic limit, exposing them to additional and more and more costs. I think we should all agree that one of the goals of this legislation should be to encourage employers who are currently providing drug coverage to their retirees to continue, in fact, to do so. It should reward and strengthen those employers because the benefit they are providing goes a long way toward helping American seniors afford prescription drugs. The legislation should not force employers to drop their coverage by making their contribution on a beneficiary's behalf meaningless or, rather, by not concluding that the employer's contribution as part of the retiree's expenditures counts toward the catastrophic limit. In other words, simply take what the employer contributes to this, include that on top of what the employee contributes, and you have a much better count toward the money that is spent toward getting to the catastrophic limit and the rate at which you get there.

Without adoption of my amendment, this plan penalizes employers who are trying to do the right thing by providing retiree health benefits. It is not in anybody's best interest for employers to decide that contributions for prescription drug coverage just keep retirees from reaching the catastrophic drug limit. Without modifying how employer contributions are treated under this legislation, we are ultimately threatening retiree coverage and driving millions more seniors to obtain Medicare coverage from their employers.

My amendment removes the so-called true out-of-pocket concept and replaces it with a real out-of-pocket concept which better reflects the seniors' true drug spending. According to CBO, the true out-of-pocket approach is a significant component of why employers drop coverage. Again, the underlying bill is the reason why 37 percent of those covered by their employers will be dropped. That I am trying to eliminate. Therefore, eliminating the true out-of-pocket expenses will go a long way toward keeping employers in the business of providing drug coverage for their retirees.

Mr. President, I urge my colleagues to adopt this amendment. I expect that the retirees in our States may well end up with a less comprehensive or more expensive prescription drug benefit as a result of this legislation should we fail to adopt this amendment.

I thank the Presiding Officer and yield the floor.

Mr. BAUCUS. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

The distinguished Senator from Iowa is recognized.

Mr. GRASSLEY. Mr. President, the Senator from West Virginia raises an important point in his amendment. In the underlying bill from the Senate Finance Committee, beneficiaries who are enrolled in both Medicaid and Medicare—and this is the group we call dual eligibles—would continue to receive drug coverage under the Medicaid Program.

Some of my colleagues have argued that by having dual eligibles remain in the Medicaid Program, Congress is thus treating these vulnerable seniors as second-class citizens and subjecting them to lower quality benefits. I strongly disagree with that point of view.

I have worked closely with my Finance Committee colleagues on the development of this package, and we had an opportunity during this debate to reflect on the concerns that were

raised by the Senator from West Virginia and also by others during the debate last summer of the so-called tripartisan bill, meaning the bill that was before the Senate in 2002.

All of us authoring the underlying bill took these concerns to heart. We made the decision that it was most beneficial to these seniors to continue to build off the existing Medicare and Medicaid low-income assistance programs that they know and understand.

That said, I remind my colleagues that the intent of this legislation is to expand prescription drug coverage to our senior citizens who do not have access to the prescription drugs and who are faced with paying a large share of their income for their drug coverage.

About two-thirds of the citizens of the United States today have some coverage for prescription drugs. Retirees from major corporations have prescription drugs paid for in their retirement plans. We have people who are in Medicare plus their Medigap policies that also have some coverage, and then we have lower income people who are dual eligibles who are covered under both Medicare and Medicaid. This makes up 60-some percent of the seniors of America who have some drug coverage.

We want to fill in the gap for those who do not have drug coverage or might have inadequate drug coverage. Quite frankly, for people who already have drug coverage, particularly those who have lower incomes, who are covered by State Medicaid Programs, we felt it was best not to upset their coverage, not to give that group any angst about how they might be covered in the future while the debate on this legislation was going on and how it might be put in motion, so we decided just to leave those as is.

The Senator from West Virginia believes it would be better if we would cover them under our plans that are meant for people who have no coverage whatsoever.

We are in a situation where coverage experienced by those who are dual eligible is the issue before us. These seniors currently have drug benefits through the Medicaid Program. In fact, many advocates and beneficiaries describe these benefits as very generous. Medicaid beneficiaries have come to know their drug benefits, along with its nominal levels of cost sharing. We should not require seniors to leave coverage with which they are comfortable.

Further, I remind my colleagues that we are discussing populations eligible for both Medicare and Medicaid. Medicaid was created to assist individuals who do not have the means to pay for their share of health care costs. That is a responsibility that is shared by the Federal Government and by State governments. Medicaid pays for many benefits that Medicare does not.

Is the purpose of the prescription drug bill before us to grant fiscal relief to the States, which would be what the amendment of the Senator from West Virginia would do? I do not believe that is what we should be doing.

We all know the purpose of the prescription drug bill is to provide prescription drugs to seniors who do not currently have access to drugs or otherwise would be paying extremely high drug costs and, hence, the provisions of our legislation for catastrophic coverage.

However, recognizing the costs associated with covering the cost of providing prescription drug coverage to dual-eligible populations, the bill before us does provide nearly $18 billion in new Federal dollars to compensate States for some of these additional costs, mostly because it is a fast growing part of the Medicaid budgets of most States.

The funding we provide in this bill will be channeled to States by federalizing the cost of Part B premiums for dual eligibles in a subclass called qualified Medicare beneficiaries. This is because the prescription drug bill before us provides minimum standards that ensure the benefit provided through Medicaid is at the same high quality that is being provided through Part D of our Medicare Program.

As is usually the case, the argument would be made yet that we should still do more and perhaps serve this population differently than we do. But, in fact, we developed the underlying bill to best utilize the availability of $400 billion, an absolute figure that we must be in; otherwise, we are subject to a point of order and, in a sense, instead of 51 votes it takes to pass this body, one could argue it would take 60 votes. If we exceeded the $400 billion, we would have to have 60 votes.

Our approach helps to deliver care that is consistent with current law but, most important, familiar to vulnerable beneficiaries.

A prime rationale behind our legislation is it really does not make seniors do anything they do not want to do. We set up a new Medicare Program that is closer to what baby boomers have in the workplace today. They can choose that or they can choose to stay in the 1965 model Medicare.

People who want to stay in the 1965 model Medicare can choose voluntarily to join a prescription drug program. They do not have to. We wanted to help those who are in Medicaid to stay in Medicaid if they wanted to. They do not have to go into these new programs.

Finally, I remind my colleagues that the adoption of this amendment will not expand coverage at all. It will simply shift the cost to the Federal Government and, in time, to other Medicare beneficiaries.

So after careful thought, because at one time we did debate internally the substance of the amendment by the Senator from West Virginia to federalize all dual eligibles, we thought maybe we should include that in the program, but we figured it raised a lot of questions from people who are already adequately covered and who seemed to be very satisfied.

Also, there are some additional costs that would subtract from what we could do for those who have no coverage for prescription drugs whatsoever, and in order to get the most bang for the dollar within the $400 billion that is in the budget for this program, we decided to leave the dual-eligible program alone. That is why I suggest we defeat Senator ROCKEFELLER's amendment when it comes to a vote.

I yield the floor.

Mr. ROCKEFELLER. Will the Senator yield?

Mr. GRASSLEY. Mr. President, the Senator will try to answer a question, yes.

Mr. ROCKEFELLER. I thank the Senator, and this is in the form of a question. I fully understand the constraints of the $400 billion, as the chairman of the Finance Committee indicates, and I think we all understood that to do a full prescription drug benefit, it was going to take substantially more than that, particularly if one included other matters. But would the Senator not agree that there are really two ways of looking at dual eligibles and their dependence now upon Medicaid which is paid by the States?

Up until the fairly recent past, States were doing very well and Medicaid benefits, to some degree, were expanding. I reflected on that as to my State. The other way of looking at it is to look at what is happening to Medicaid now in the States because of the balanced constitutional amendment requirements and because of the fiscal condition of the States, which is getting worse every single day, and the fact that Medicaid is the fastest rising cost in any State government budget, and the fact that the States have complete control over what happens to the Medicaid benefit.

So would the Senator from Iowa not agree that if a State using Medicaid, which is a combination of State and Federal funds, nevertheless decides to cut—since that is optional within the State, under the Government's control, that the Governor can cut that and indeed has done so, as we have been reading and hearing about, and indeed can limit coverage, cap coverage and therefore cut back tremendously on the so-called drug coverage that the chairman of the Finance Committee was extolling?

I agree that if we were in a flush time and the States were able to afford a good drug benefit under Medicaid and use it for that particular dual-use population, the Senator is right, but I think we are looking now at a period of a number of years where we are not going to be in that situation. I think that puts the dual eligibles, 74 percent or less of poverty, at terrible risk, and that is not something I associate with my understanding of the values of the Senator from Iowa, whom I so much respect.

Mr. GRASSLEY. Mr. President, I cannot disagree with the Senator from West Virginia, but I think the answer is that there are 50 different answers to his question from the standpoint of there being 50 different States with 50 different budget situations. So there is not just one answer to his question.

Another way to say it is I would have to understand the situation in 50 different States and then, in a sense, give 50 different answers. But there is a recognition on the part of the Congress of what the Senator from West Virginia says and a response by the Federal Government to that, albeit a temporary response, when over a 2-year period of time we decided to put $20 billion of State aid to the States, and we did that through the tax bill recently signed by the President of the United States, of which $10 billion was earmarked for Medicaid solely because the Congress understood the problems the Senator from West Virginia has adequately described, and then another $10 billion of other State aid that a State is free to use for Medicaid or anything else.

I assume some States that have very bad Medicaid fiscal problems might take some more of that additional $10 billion to use for Medicaid.

In further answer to my colleague's question, what we face is the issue of about $16 billion a year just for drug costs. Multiply that times the 10 years we have to look ahead. That is about $160 billion, I believe, of the $400 billion which would go then for groups who are already covered, detracting then from the 30-some percent of people who have no prescription drug coverage.

We would like to fill in the gap of those who have no coverage as opposed to some who have very good coverage. I know it varies from State to State how Medicaid might cover certain groups of seniors with prescription drugs, but I think the Senator would say they have had a better program for sure than most people—except maybe those who are on a corporate retirement plan, which is only about 30 percent of our people—than anybody else, particularly those who have no coverage whatsoever.

In further answer to the question of the Senator from West Virginia, it is a case of priorities. We have suggested those who already have some coverage, and very good coverage, we would basically leave untouched and then would try to use our resources for those who have no coverage whatsoever.

The PRESIDING OFFICER. The Senator from West Virginia.

Mr. ROCKEFELLER. I apologize for not speaking through the Presiding Officer before, but will the Senator from Iowa yield for only one additional question?

Mr. GRASSLEY. I yield for an additional question.

The PRESIDING OFFICER. The Senator is recognized.

Mr. ROCKEFELLER. The Senator has responded simply by saying he would have to answer it in 50 different ways because there are 50 different States. To that I say yes, and all of them are either in the process of or will be in the process of cutting Medicaid and, therefore, the dual beneficiaries.

I ask the Senator from Iowa, is there not a further consideration, and that is when we are dealing with this maximum poor number of people under Medicare, or Medicaid in the case of the dual eligibles, we are also dealing with something which has not been discussed on this floor or indeed was not discussed in the Finance Committee at any length at all, and that is a really frightening problem of assets that, for example, one can apply, one can be under this program up to 130 percent of poverty. Then there is another one that says you can be under this Part B plan up to 160 percent of poverty, but if your assets reach over $4,000, assets which you maintain, you are then kicked from the lower to the upper bracket without any discussion. There is enormous penalty, for example, for owning a car, for owning anything. You would not be living in rural Calhoun in West Virginia without a car. Your home is exempted but nothing else is.

At one point I was thinking of offering an amendment—and I may still do so—exempting burial plots from the asset test that would be applied to poor people.

I ask the Senator from Iowa if he would say a word on this whole question, adding to the dual eligibles and deciding if—as he said, we have to pick our priorities—we are going to leave it to the States, even though I argue that States will cut that. Is it not also bringing up this whole subject of the assets of the poor families and the effect on them if they become ineligible for the bracket in which they belong and, therefore, cannot afford prescription drugs.

Mr. GRASSLEY. Mr. President, I will answer the Senator's question by giving some detail about the issue of the asset test. It is a legitimate point of discussion as we deal with this legislation. Rather than just speaking specifically to his question, I answer it more generally with how we try to respond to the issues he brought up.

The asset test in the underlying bill is the same asset test currently used for determining eligibilities for the qualified Medicare beneficiaries, specified low-income Medicare beneficiaries, and qualified individuals. Those are three separate categories of low-income people that I just described.

S. 1 provides a generous low-income subsidy for those who are below 160 percent of the Federal poverty level. Currently, in order for some individuals under 160 percent of poverty to receive limited Medicaid protections, there must be both an income test and an asset test. In the underlying bill, we simply follow the same rules in order for low-income beneficiaries to see assistance with their prescription drug coverage. By including the Medicaid asset test for Medicare prescription drug subsidies, we are providing beneficiaries with seamless health coverage. We are not confusing beneficiaries, and we are not adding additional administrative burdens to the States.

I will give some background on the current asset test included in the Medicaid Program. The group called qualified Medicare beneficiaries are individuals below 100 percent of poverty. In 2006, the annual income limit is $9,670 for individuals and $13,051 for couples. This qualified Medicare beneficiary group is allowed to have assets below $4,000 for individuals and $6,000 for couples. That is exactly what the Senator from West Virginia asked me about and implied some limitations because of that.

Yes, there are limitations because of that, but they are legitimate limitations within the priorities of our $400 billion budget limit.

Then we have the category of specified low-income Medicare beneficiaries, and then the qualified, and those are people with incomes between 100 percent of poverty and 135 percent of poverty. In 2006, the annual income limits of this group, $13,054 for individuals, $17,618 for couples, these two groups are allowed to have assets below $4,000 for individuals and $6,000 for couples. Beneficiaries between 136 percent of poverty and 159 percent of poverty will have annual income limits of $15,472 for individuals and $20,881 for couples in 2006. Beneficiaries between 136 and 159 percent of poverty would not be subject to those asset rules.

Current law establishes resource limits for low-income elderly or disabled individuals. Let me emphasize, this is not a newly added restriction on certain low-income Medicare beneficiaries. However, current law also provides States with the flexibility to choose to disregard all or part of these resources.

The issue of changing this asset test is one that would very drastically increase the number of eligible beneficiaries. Understand that the question the Senator from West Virginia raised about changing the asset test would very dramatically increase the number of people eligible.

Now, again, we get back to the priorities of fitting in the $400 billion in the budget. Give more help to this group of people that already have some help from our legislation, then there is less for other people, particularly less for people who have no help whatever.

A study was prepared by the Kaiser Family Foundation estimating this group could be as many as 11 million individuals if the asset test were eliminated and obviously to a lesser extent if it were increased by some amount.

S. 1 currently includes a provision requiring the General Accounting Office to conduct a study and make recommendations to Congress by the year 2007 regarding the extent to which drug

utilization and access to covered drugs differs between qualifying dual eligibles who receive subsidies and individuals who do not qualify solely because of the application of the asset test. This report ensures that there will be opportunities in the future to debate the question raised by the Senator from West Virginia.

There is a limited number of dollars available for the Medicare drug benefit. In the writing of this bill, we made a conscious decision to devote excess dollars to filling the gap in coverage—which means what we commonly refer to around here as the donut hole—rather than eliminating or changing to some extent the asset test the Senator from West Virginia is asking me about.

This bill already provides generous coverage to low-income seniors. This amendment will not only cost more money, it will add more confusion to both States and Medicare beneficiaries.

I hope I have sufficiently explained the rationale behind our bill. I may not have directly answered the question of the Senator from West Virginia, but I thought I should take time to explain the rationale behind our bill.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BAUCUS. Mr. President, I would like to say a couple of words about one of the two amendments offered by the distinguished Senator from West Virginia regarding the true out-of-pocket expenses, where the employers' contributions to retirees' health care plans be considered in calculating the out-of-pocket expense that would determine when a senior citizen reaches the stop loss provisions of this bill.

This may sound like a fairly arcane point, but it is a very important one.

Let me just describe the provisions of the bill. Under the bill, after a $275 deductible, the provisions of this bill require that employees would receive a contribution from the Government of 50 percent of each prescription he or she filled, up to $4,500 in drug expenses. After that amount, $4,500, then seniors would pay 100 percent of the costs until the beneficiary's spending reached $3,700. This should not be confused with total spending, of which the beneficiary spent $3,700 out of his pocket. It would be $5,812.

Anyway, after the beneficiary spends $3,700 out of pocket, the total stop loss coverage kicks in and the Government picks up 90 percent of the beneficiary's drug spending and the beneficiary, him or herself, pays 10 percent.

The real question is, What about the employers' contributions? Would they count toward the stop loss coverage? Under the underlying bill, all spending must be provided by the beneficiary, not on behalf of the beneficiary. As a consequence, employers' contributions would not count. The CBO estimates up to 37 percent of retiree health coverage would therefore be dropped by employers.

Just to recapitulate, the amendment offered by the Senator from West Virginia basically provides that the stop loss amounts in the underlying bill should be based on out-of-pocket costs, and the employers' contribution towards retiree health benefits could count towards that stop loss computation.

What about this? Frankly, I have a lot of sympathy for the Senator's amendment. That is, as it currently stands, the beneficiary, a senior citizen, would have to spend $3,700 before the stop loss would be calculated. Under the amendment offered by the Senator from West Virginia, that amount would be quite a bit lower.

I mentioned earlier that CBO estimates about 37 percent of retirees who now are covered by health plans under their employer health coverage would no longer receive drug coverage because those employers would drop coverage. Or, to say it differently, CBO estimates that, because the employer's contributions do not now count towards stop loss, about 11 percent of the seniors generally would lose their employer-sponsored health coverage.

As I mentioned, I share my colleague's desire to prevent the loss of employer-sponsored coverage; that is, to the extent possible. We have our work cut out for us because retiree coverage is already on the decline. According to the Kaiser Family Foundation/Hewitt Study, that was released last December, one in five large employers is likely to eliminate retiree health coverage for future retirees in the next 3 years.

That is a lot. That is irrespective of the provisions of this bill with respect to prescription drug coverage. If one out of five large employers in fact does eliminate retiree health coverage for their retirees within the next 3 years, it is going to have a huge impact, clearly, on those retirees, and also on the portion of the health care system that is not paid for by larger companies.

That study also found that nearly 80 percent of large employers are likely to increase the amount paid directly by their employees for health care. That is, most—four-fifths of all employers—are likely to have their employees pay more than they, the employers, are paying. We know about the negotiations between General Electric and its employees not too long ago, where both agreed to shift more of the rising cost of health care to employees. Clearly, we should be doing all we can to ensure that a bad situation does not get worse.

The chairman of the committee, Senator GRASSLEY, and I have been looking for ways to address concern about employer-sponsored coverage. We are looking at ways to make employers' participation in the new Part D benefit more manageable, so employers have flexibility with respect to the offering of these benefits. I, certainly, personally am willing to entertain proposals that would allow more employer coverage, and also help address the out-of-pocket situation the Senator from West Virginia would like to cover with his amendment.

The slight problem we have, as most of us know, is that we are working within the confines of $400 billion over 10 years. If the amendment offered by the Senator from West Virginia were to be agreed to, according to CBO, that would cost approximately $65 billion. That is $65 billion, generally, over the $400 billion that has been set aside for this bill. Senator GRASSLEY and I are working with various groups in and out of the Senate, trying to address the potential loss of employer retiree coverage. It is a great concern of ours. There have been several proposals offered as to how we might deal with that, in addition to the ones contained in the amendment by the Senator from West Virginia. I am hopeful that during the next several days, before the final passage of this bill—hopefully before the weekend—we will be able to significantly address this issue. So far, we do not have it nailed down. But as you might expect, this and a lot of other issues are kind of hovering about as we try to find ways to fit the pieces together so we can get a very good bill passed.

I also remind my colleagues who are slightly concerned about the complexity of this bill—and this bill is somewhat complex—there was an interesting piece in, I think it was today's New York Times; it might have been yesterday's. In any event, it was about the complexity of the bill and how bewildered some people are because of the complexity. I think the article did a good job in explaining why major social policy, almost by definition, is complex; that is, it is a result of compromises.

In this case, the big compromise is between about half of this body, who wants to provide prescription drug benefits under Medicare, and about half of this body, who wants prescription drug benefits to be provided under private competition. It is difficult to put those two pieces together. It is the attempt to put those two pieces together that has caused a lot of the complexity that does exist in this bill.

I might say, however, that Medicare itself is already quite complex. They could come back and say: Why make something complex even more complex? But it has to be weighed against another factor. That is, do we want to provide a prescription drug benefit to seniors or not? The choice at the end of this week is going to be, do we want something that is a little bit complex but provides prescription drug benefits for seniors—and does a good job doing so? Maybe with not as many benefits as

some seniors would like and some Members of this body would like, but still does a pretty good job and is a bit complex. Or, on the other hand, do we want to do nothing? Do we want to let senior citizens today, who do not have prescription drug coverage, remain without coverage? That is basically the question we are going to be facing later on this week.

To ask the question, I think, is to answer it. Namely, we should do a pretty good job, trying to get a pretty good bill passed, even though there is some complexity, even though there are some tradeoffs, rather than have nothing.

I suspect this body is always going to be somewhat split. I do not think one party is going to be totally in control at one time or the other party is going to be totally in control at another time. I think it is the nature of the American body politic that people want to hedge their bets, that they want to have both Democrats and Republicans working together. Certainly, our Founding Fathers set up our Government that way under our Constitution. They absolutely distrusted power. They distrusted it almost absolutely. That is why we have power dispersed by definition. That means in order to get something of consequence passed, there is going to have to be some compromise. In this bill there certainly is a lot of compromising.

A final point contained in that article—and I thought it was a pretty good article—is that when we, in this country, have passed other major social policy—let's say Medicare and Social Security—it has been based somewhat on faith, and we have worked to fix it, to make it even better after it has been passed. But you have to start somewhere. And I think, certainly, we have to start somewhere with respect to prescription drug benefits, and certainly, we should provide prescription drug benefits for seniors.

So I urge my colleagues to keep that in mind as we are working on amendments, which are designed to make this bill better. We can accept some amendments, but some in this body will not accept others. Nevertheless, all of us are generally working together toward the same goal.

In that vein, Mr. President, I ask unanimous consent that the pending amendments be temporarily set aside so the Senator from Hawaii may offer two amendments in sequence.

The PRESIDING OFFICER (Mr. SUNUNU). Is there objection?

Without objection, it is so ordered.

The Senator from Hawaii.

AMENDMENT NOS. 980 AND 979

Mr. AKAKA. Mr. President, I rise today to offer amendment No. 980 to restore Medicaid and State Children's Health Insurance Program eligibility for children and pregnant women who are citizens from the Freely Associated States and reside in the United States lawfully. The United States entered into a Compact of Free Association with the Federated States of Micronesia and the Republic of the Marshall Islands in 1986, and with the Republic of Palau in 1994.

The political relationship between the United States and the FAS is based on mutual support. In exchange for the United States having strategic denial and a defense veto over the FAS, the United States provides military and economic assistance to the RMI, FSM and Palau with the goal of assisting these countries in achieving economic self-sufficiency following the termination of their status as U.N. Trust territories. Pursuant to the Compact, FAS citizens are allowed to freely enter the United States and are not considered immigrants.

Legal immigrants and FAS citizens lost many of their public benefits as a result of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. I appreciate the work done by my colleague from Florida, Senator GRAHAM, to restore the eligibility for Medicaid and SCHIP for legal immigrants who are children and pregnant women.

The language that has been included in S. 1, the Prescription Drug and Medicare Improvement Act, would give States the option to provide this coverage and allow them to use Federal resources to do so.

However, the current text does not restore these benefits to citizens from the FAS lawfully residing in the United States. Arguably, FAS citizens have strong ties with the United States as they come from the countries that are perpetually bound to the United States in free association.

It is important for Congress to restore these benefits for FAS citizens that were taken away from a relatively small but important population. The Congressional Research Service estimates that 11,500 FAS citizens have migrated to the United States since the Compact was enacted. They have come to the United States to seek economic opportunity, education, and access health care.

The State of Hawaii, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands have supported FAS citizens with necessary health care services, but not without significant and increasing costs. The Federal Government must provide matching resources to help States meet the health care needs of FAS citizens and to meet the obligations of the Federal commitment.

I urge my colleagues to support this amendment to restore a portion of the benefits that were taken away from FAS citizens in 1996.

Mr. President, I have another amendment, amendment No. 979, to offer to S. 1.

The PRESIDING OFFICER. Does the Senator wish to offer both amendments?

Mr. AKAKA. The amendments are at the desk.

The PRESIDING OFFICER. The Senator will be advised, neither amendment has been reported by the clerk.

Without objection, the clerk will report both amendments.

The legislative clerk read as follows:

The Senator from Hawaii [Mr. AKAKA] proposes amendments numbered 980 and 979.

Mr. AKAKA. Mr. President, I ask unanimous consent that reading of the amendments be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendments are as follows:

AMENDMENT 980

(Purpose: To expand assistance with coverage for legal immigrants under the Medicaid program and SCHIP to include citizens of the Freely Associated States]

On page 636, line 16, insert ''and citizens of the Freely Associated States, which include the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau, lawfully residing in the United States'' after ''Act''.

AMENDMENT 979

(Purpose: To ensure that current prescription drug benefits to medicare-eligible enrollees in the Federal Employees Health Benefits Program will not be diminished)

At the appropriate place, insert the following:

SEC. . NEGOTIATIONS BY THE OFFICE OF PERSONNEL MANAGEMENT.

The Office of Personnel Management may not negotiate a prescription drug benefit for any health benefits plan under chapter 89 of title 5, United States Code, that would provide a prescription drug benefit to a medicare eligible enrollee in that plan that is of lesser actuarial value, based on 2003 constant dollars, than the prescription drug benefit available to a medicare eligible enrollee of such plan on the date of enactment of this Act.

Mr. AKAKA. Mr. President, amendment No. 979 would ensure that the Federal Employees Health Benefits Program could not reduce the level of prescription drug coverage available to Medicare-covered Federal civilian annuitants. I thank my colleague from Maryland, Senator MIKULSKI, for cosponsoring the amendment.

I strongly support the creation of a prescription drug benefit for Medicare beneficiaries. Thirty-eight percent of Medicare beneficiaries report that they do not have prescription drug coverage. Far too many seniors are unable to afford the medications that they need, and the establishment of a prescription drug benefit will provide much needed access to medications that our seniors desperately need.

However, the Congressional Budget Office believes that Medicare drug coverage authorized by this bill is likely to act as an incentive for employers to drop their employer-sponsored drug benefits. An estimated 37 percent of retired workers with employer-sponsored drug benefits could lose their coverage under this bill according to CBO. I am troubled that older Americans who already have earned coverage through an employer-sponsored plan could lose their existing benefits. We have seen over the past few years that there has been a disturbing trend of reducing benefits for retirees. Creating this voluntary benefit could only accelerate this trend.

The intent of the legislation is to expand prescription drug coverage for seniors, not merely to shift the financial burden of existing coverage to the Federal Government. If Medicare beneficiaries lose their employer-based coverage, they may have to pay more for a Medicare drug benefit that provides less comprehensive coverage.

We must encourage employers to maintain their current coverage, and I will support efforts to do so. We should not shift the existing costs of prescription drug coverage to the Medicare program. If this occurs, there will be fewer resources available to pay for the medications of those who currently need insurance.

My amendment will ensure that present and future Federal retirees retain their current level of prescription drug coverage. They should not face a situation in which they must rely on Medicare. My amendment requires the FEHBP to preserve current-level drug coverage for Federal retirees and survivors. The Government health care plan stands as a model employer-sponsored health care plan, and my amendment protects the Nation's Federal annuitants and their survivors. Accepting this amendment sends a message to other employer-sponsored plans that the Federal Government stands behind its commitment to retired workers.

I ask unanimous consent that letters from the National Association of Retired Federal Employees and the National Treasury Employees Union in support of my amendment be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

THE NATIONAL
TREASURY EMPLOYEES UNION,
June 23, 2003.

RE: S.1, Medicare Drug Proposal

DEAR SENATOR: On behalf of the more than 150,000 federal employees and retirees represented by the National Treasury Employees Union (NTEU), I am writing concerning S.1, legislation to provide prescription drug coverage under Medicare.

NTEU believes legislation to provide prescription drug coverage for Medicare beneficiaries is long overdue, however, we have serious reservations concerning the way that this benefit has been structured. The proposed new benefit would provide a substantially less valuable benefit to Medicare beneficiaries than many private sector employers already provide for their retirees. Employers must not be permitted to diminish the prescription drug coverage they provide to former employees as a result of passage of this new Medicare benefit. Although we do not believe that is the intent of this legislation, steps must be taken to prevent this unintended consequence from occurring.

The federal government provides health insurance benefits, including prescription drug coverage, to its employees and retirees through the Federal Employees Health Benefits Program (FEHBP). Any proposal that would encourage, or result in, the federal government moving away from its commitment to its employees and retirees in this area would be strongly opposed. The fact that the Congressional Budget Office has reported that as many as 37 percent of retired workers would lose their employer-provided drug coverage as a result of passage of S.1 provides serious cause for concern.

Senator Akaka plans to offer an amendment that seeks to address this issue. His amendment would prohibit the Office of Personnel Management (OPM) from negotiating a prescription drug benefit for Medicare-eligible FEHBP enrollees that is less valuable than the benefit available to those enrollees on the date of enactment of the pending Medicare drug proposal. The Akaka amendment makes sense and is consistent with the intent of the Medicare legislation—that employers already providing prescription drug benefits to their retirees continue to offer their existing benefits packages.

Our goal is two fold: to provide Medicare beneficiaries with the best possible drug benefit while at the same time ensuring that retirees who enjoy prescription drug coverage through employer-sponsored plans retain that coverage. I urge your support for the Akaka amendment.

Sincerely,

COLLEEN M. KELLEY,
National President.

NATIONAL ASSOCIATION OF
RETIRED FEDERAL EMPLOYEES,
Alexandria, VA, June 24, 2003.

Hon. DANIEL K. AKAKA,
Senate Office Building,
Washington, DC.

DEAR SENATOR AKAKA: On behalf of the 400,000 member National Association of Retired Federal Employees (NARFE), I am writing to endorse your amendment to S. 1, the Prescription Drug and Medicare Improvement Act of 2003, that would ensure that the Office of Personnel Management (OPM) could not reduce the level of Federal Employees Health Benefits Program (FEHBP) prescription drug coverage currently available to Medicare-covered Federal civilian annuitants through negotiations with participating carriers.

NARFE strongly supports the creation of a Medicare drug benefit for our senior citizens who have no drug coverage. But at the same time, we want to ensure that no harm is done to older Americans who already have earned such coverage through an employer-sponsored plan. As you know, the Congressional Budget Office estimates that 37 percent of retired workers with employer sponsored drug benefits could lose it under S. 1.

The CBO believes that Medicare drug coverage authorized by this bill could act as an incentive to employers to drop their employer-sponsored drug benefits. If that occurred, retirees would be forced to pay an additional monthly premium for a Medicare drug benefit that would be limited and more costly than what is currently available through many employer-sponsored health plans, including the FEHBP. The last thing Medicare reform should do is encourage employers to break promises made to their retirees regarding their earned health security.

While the Medicare reform bill that is eventually enacted may provide subsidies and tax credits to private employers who retain existing drug benefits for their retirees, such incentives would not apply to the Federal government, and thus provides no guarantee of the FEHBP drug benefit for the government's own annuitants. If FEHBP is the model for this reform, the Federal government itself must not drop or reduce drug benefits for FEHBP enrollees. Your amendment recognizes this principle of fairness and would help to ensure that S. 1 does no harm to those men and women who have served and continue to do so much for our nation. NARFE commends you for valuing the importance of the earned health security of the more than 4 million Federal workers and annuitants and we give our strongest endorsement to your amendment.

Sincerely,

CHARLES L. FALLIS,
President.

Mr. AKAKA. Mr. President, I urge my colleagues to support my amendment and look forward to working with them to ensure drug coverage for retirees under other plans.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I ask unanimous consent that all pending amendments be temporarily set aside so the Senator from Arkansas may offer an amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Arkansas.

AMENDMENT NO. 981

Mr. PRYOR. Mr. President, I have an amendment at the desk.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Arkansas [Mr. PRYOR] proposes an amendment numbered 981.

Mr. PRYOR. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To provide equal access to competitive global prescription medicine prices for American purchasers)

At the appropriate place, add the following:

SEC. ___. EQUAL ACCESS TO COMPETITIVE GLOBAL PRESCRIPTION MEDICINE PRICES FOR AMERICAN PURCHASERS.

(a) DEFINITION OF COVERED PRODUCT.—In this section, the term ''covered product'' has the meaning given the term in section 804 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 384).

(b) PROHIBITION.—It shall be unlawful for the manufacturer of a covered product or any other person that sells a covered product to refuse to sell to any wholesaler or retailer (or other purchaser representing a group of wholesalers or retailers) of covered products in the United States on terms (including such terms as prompt payment, cash payment, volume purchase, single-site delivery, the use of formularies by purchasers, and any other term that effectively reduces the cost to the manufacturer of supplying the drug) that are not substantially the same as the most favorable (to the purchaser) terms on which the person has sold or has agreed to sell the covered product to any purchaser in Canada.

(c) ENFORCEMENT.—The Secretary of Health and Human Services, or any wholesaler or retailer in the United States aggrieved by a violation of subsection (b), may bring a civil action in United States district court against a person that violates subsection (b) for an order—

(1) enjoining the violation; and

(2) awarding damages in the amount that is equal to 3 times the amount of the value of the difference between—

(A) the terms on which the person sold a covered product to the wholesaler or retailer; and

(B) the terms on which the person sold the covered product to a person in Canada.

(d) EFFECTIVENESS OF SECTION.—This section takes effect on the date that is 2 years

after the date of enactment of this Act, except that this section shall not be in effect during any period after that date in which there is in effect a final regulation promulgated by the Secretary of Health and Human Services permitting the importation or reimportation of prescription drugs under section 804 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 384).

Mr. PRYOR. Mr. President, I rise to address the Chamber about my proposed amendment that fits very neatly with an amendment that passed last week 62 to 28. It is a fallback amendment to that Dorgan-Cochran proposal.

The way I view this amendment—I hope the way my colleagues will understand it—it is really an antiprice gouging amendment as we go through the process and hopefully add a prescription drug benefit to Medicare that so many people in the country want and deserve.

We all know the stories about drugs that are produced in this country that are made at certain plants and certain places. And when they leave the plant, one truck will go to one of our home States and the other truck will go to Canada. Unfortunately, what happens all too often is when the drugs get to Canada, they are about one-half or one-third or one-quarter the price that people can buy those drugs in the United States. In my opinion, there is no valid reason for that. There is no valid justification for those drugs to be priced in that way.

We also know the Senate has tried to address this problem on at least a couple occasions—in the year 2000 and in the year 2002. This very Chamber voted to allow the reimportation of pharmaceuticals from other countries. Of course, the reimportation of drugs would be FDA-approved drugs coming out of FDA-approved facilities. In fact, for the third time in 4 years, the Senate voted this past Friday to allow the same thing.

Currently, the law is reimportation can come from a list of countries. There is a designated list. That has been somewhat cumbersome. And the FDA has not seen fit and has not been able yet to approve this process because they can't certify or verify that the drugs are safe. One thing I like about the Dorgan-Cochran amendment is it limits the scope of reimportation only to Canada. That is a significant advancement because we all know that Canada has very high medical standards and that they are very concerned about their populous and the veracity of medication in their society.

My proposal also is limited just strictly to Canada. One advantage is that they have a very similar, almost identical set of standards for handling drugs to make sure that there is a chain of custody, proper testing, et cetera. They build in the safeguards just as we do. A lot of countries don't do that. But with Canada we have a certain degree of confidence—maybe not absolute; I guess you can never have an absolute degree of confidence—that drugs are going to be safe. We have a very high degree of confidence that the drugs will, in fact, be safe and they will meet U.S. standards.

Let me briefly address my amendment. It is only three pages—very simple, very straightforward. In terms of the definition of covered product, we adopt the existing law. Therefore, there is no surprises, no monkey business or games played with the definition. When it comes to the prohibition in section B, which is found on page 2 of the amendment, in summary—I will delete all the commas and the parenthetical phrases, but in summary it says: It shall be unlawful for the manufacturer of a covered product to refuse to sell to any wholesaler or retailer—and that is key—on terms that are not substantially the same as that of any purchaser in Canada.

Let me run through that very quickly, if I may. One of the keys is that it is for wholesalers and retailers. What that means is that wholesalers and retailers in this country can reimport from Canada.

We all know if our local pharmacist could somehow work out an arrangement with wholesalers and retailers in Canada, they could actually buy the products in Canada, have them shipped to the United States, and sell them cheaper here than they can buy them wholesale in this country.

One of the keys is that American wholesalers and retailers are subject to all the FDA rules and regulations and requirements.

Therefore, this amendment will only allow the reimportation of safe FDA-approved products made at FDA-approved facilities. When it comes to enforcement, this amendment would allow the Secretary of Health and Human Services, as well as any wholesaler or retailer in this country that is aggrieved by some unfairness—the thing I like about that and I hope my colleagues understand—it allows both the Government sanction, the ability to enforce this, but also the free market. We all know the free market works very well, and when a free market can regulate itself, I think we are all better off. It has the ability for the Government to enforce this if necessary.

In the last bit, on page 3 of the amendment, it deals with the timeframe. That is a 2-year provision from the enactment of this act that this will take effect. In other words, the way this works is, once we pass this legislation, the President signs it, it becomes effective 2 years after it is enacted. Then it will trigger this act if the FDA has not issued its final regulations. Then we will be able to purchase these drugs at the same prices they get in Canada. In other words, it is an antiprice-gouging mechanism that I think is critical to this legislation and to its long-term success.

I very much applaud the leadership in this Chamber, especially coming from Chairman GRASSLEY and Senator BAUCUS, Senator FRIST, Senator KENNEDY, Senator DASCHLE, Senator GRAHAM, and, of course, Senators DORGAN and COCHRAN have shown leadership not just on this issue but on prescription drugs generally. I thank them for getting this to the Senate floor and allowing this very important debate and allowing these important amendments to be considered.

I do believe very strongly that when the bill came to the floor, it was a bill definitely worth our consideration. But I also think and believe very strongly that the bill has improved since it has been on the floor. I think these amendments are making the bill stronger and better for the American public.

For example, the Enzi amendment, which I like quite a bit, makes sure that people will still have access to use their local pharmacists. Not only are many pharmacists pillars of the community, not only do they do great things in their communities, but so often patients getting prescription drugs need to talk to their pharmacist about drug interactions, expiration dates, and details of how to take it. It is very important for the effectiveness of the drug that people talk to a local pharmacist and have access thereto. So I thank Senator ENZI for doing that.

The Gregg-Schumer-McCain-Kennedy amendment closes loopholes to allow name-brand drug manufacturers to unfairly extend their monopolies and overcharge American patients. This has been going on for a long time and it is something, when I was Attorney General, we worked on very hard to try to stop from the litigation standpoint. But now Congress has taken action, and I am so pleased that they are stopping this legislatively.

We have mentioned the Dorgan amendment, with the Cochran second-degree amendment, and how that has strengthened the bill and how, hopefully, that will cause prices to stabilize and, in fact, hopefully, come down over time. I think there is still some work to be done on this bill, and I think during the course of this week there will be a lot of great amendments to consider. I hope I can vote for some of those. When I believe it will make this bill better, I will support it.

Let me run through the chart very quickly. What we see is a graph with two lines. You can see that this lower line says ''health.'' If you were to look at the consumer price index, or one of the other indexes, it would be even lower than this green line, but it would go up slightly. That is, of course, the inflation rate, and it goes up 2, 3 percent a year.

Right here, we see the health care costs. If you go back to 1994—our baseline year—the price, the cost of health care, in just these 7 or 8 years has gone up 63.6 percent. One thing we all hear from our constituents is how much health care costs are increasing. For a lot of people, they have increased 10, 15 percent—sometimes more—a year. It is strangling people.

If you look inside the numbers and you look at the No. 1 cause of health

care costs going up, it is the cost of prescription drugs. That is what this red line indicates. Again, you can see the rapid growth that is outpacing the costs of health care and inflation, and it is pulling health care costs up and in a very dramatic fashion. I think pretty much everyone who has looked at this nationally agrees that it is the high cost of prescription drugs that is the primary reason—there are other factors—why health care costs are going up so dramatically.

In this proposal—not in my amendment but in the actual bill—we are talking about having a $250 deductible and a stop loss protection that kicks in, paying 90 percent of drug costs after $3,700 of out-of-pocket spending. Well, one thing the American public needs to understand, and all of us Senators need to remember, is that these are percentages and they will go up as the costs of prescription drugs go up. So one thing we need to be very mindful of is, as we watch this red line, the top numbers on this particular chart, go up—in fact, CBO says about 12 percent a year, and they are taking average numbers. They have been going up more than 12 percent per year in the last few years. If we say more than 12 percent a year, after 5 years that deductible of $250 becomes a deductible of $485. In fact, the stop loss threshold goes from $3,700 to $6,521. Both of these adjust based on cost of prescription drugs—not based on the cost of health care or on the cost of an increase in inflation but based on the cost of prescription drugs. What that means is that in 10 years the deductible will go to $854, and the stop loss in 10 years will be $11,492.

Now, what this amendment is designed to do is to try to get ahold of these runaway costs of prescription drugs. As long as these numbers go up like this, the problems in this bill—things that we as Senators don't like about this bill, like the gap in coverage, the deductibles, and the stop losses—are going to get worse. It is going to do nothing but get worse over time.

So what this amendment and what the Dorgan-Cochran amendment are designed to do is to try to somehow keep prescription drug costs down in a very reasonable way. That is why reimportation is so critical because reimportation, in the strange world of prescription drugs, introduces competition into the marketplace. Suddenly, the drug costs here are competing with the drug costs in Canada, and what that will result in, necessarily, is lower drug costs if free market principles are allowed to apply.

While I am 100 percent convinced the administration can and should implement Senator DORGAN's and Senator COCHRAN's amendment, I am not 100 percent sure they will do it. Recently, we received a letter in the Senate from the FDA from one of the Commissioners, Mr. McClellan. Let me quote, if I may, from Mr. McClellan's letter. I may have to put on my reading glasses to do this because that is what happens when you get old, Mr. President. I know I am quite a bit older than the occupant of the Chair. When you get my age, you need these.

THIS is a letter to Senator THAD COCHRAN, and it is from Mark B. McClellan, FDA Commissioner, sent earlier this month, on June 19, 2003. It says:

> The overall quality of drug products that consumers purchase from the United States pharmacies is very high, and the American consumer can be confident that the drugs they use are safe and effective.

That is a key point because we have a very safe marketplace for drugs. In fact, one of the things I did when I was attorney general of my State—and I left there 6 months ago—I sent out periodical consumer alerts to Arkansans about being very careful about buying drugs over the Internet, using mail order companies, and toll-free numbers because sometimes, under some circumstances, you are not sure what you are getting.

We always advise people to be very careful when they do that. I have a bias and a preference for using a local pharmacist.

Let me continue. I am skipping around:

> In FDA's experience, many drugs obtained from foreign sources that either purport to be or appear to be the same as U.S.-approved prescription drugs are, in fact, of unknown quality.

That is something we found in the attorney general's office in Arkansas when I was there.

The letter goes on to say:

> These outlets may dispense expired, subpotent, contaminated, or counterfeit products, the wrong or contraindicated product in an incorrect dose or medication unaccompanied with adequate direction for use. The labeling of the drug may not be in English and important information regarding doses and side effects may not be available. In addition, the drugs may not have been packaged and stored under proper conditions to avoid degradations.

That is true. That definitely happens. We have seen that time and again around this country. But that is one of the great points about the Dorgan amendment. In fact, the Dorgan amendment that was adopted last week with 62 votes has a provision—I am not going to read it all—on page 3 that makes it very clear that we can only reimport FDA-approved drugs at FDA-approved facilities. There has to be documentation; there has to be testing. The safeguards are there.

Also what Mr. McClellan is talking about here is a very serious problem, but by the very same standards he is referring to in his letter, he cannot guarantee that American drugs are safe because we all know in the marketplace there are some problems—a very small percentage in the United States but there are some problems. He goes on to say FDA cannot guarantee the safety of Canadian drugs. As I said, really in a true sense, we cannot guarantee the safety of American drugs either, but the FDA does a very good job.

Interestingly enough, my staff, as we were preparing to be here this afternoon, went on Lexis-Nexis and did a search to find all the reported cases in recent years from Canada related to counterfeit drugs. They could not find one case, one newspaper article, one incident, anything that was reported about counterfeit drugs in Canada. That is using the Lexis-Nexis search. The truth is, we found a number of those in the United States, but we did not find any in Canada.

Lastly, Mr. McClellan's letter to Senator COCHRAN says:

> At this time, the agency simply cannot assure the American public that drugs imported from foreign countries are the same as products approved by the FDA and that they are safe and effective.

Again, our bill fixes this problem because my amendment, along with Senator DORGAN's and Senator COCHRAN's amendment, says it only applies to FDA-approved drugs and it is only from Canada. We have a much more confident sense about the Canadian marketplace for prescription drugs than we do about a number of other countries.

Back when President Bush was running for office in 2000, he had the same impression as most of us when we think about this issue for the first time. He said ''it made sense'' to allow prescription drugs that were sold overseas to come back. I think he was right about that. It does make sense, as long as we build in the proper safeguards. Again, I think the amendment Friday and my amendment today will do that.

Some say that doing anything to make prescription drugs more affordable will reduce investment in research and development. I disagree. There are many factors that go into research and development, and two of those—and I hope people understand this—two of the major reasons drug companies come here to do their research and development are:

First, we make a huge public investment through the NIH, the National Institutes of Health. They do a lot of the basic research that the drug companies then build on and actually produce prescription drugs.

Second, this country provides a research and development tax credit, and the drug companies take advantage of that, and they should. It is there for them to take advantage. That is why we have it. It is good for the country. It is good for the economy. It is good for our health. I am supportive of those tax credits.

But those are two taxpayer-funded—I do not know if you want to call them subsidies. Call them what you want but those are two taxpayer incentives for these big drug companies to do research and development: The huge public investment we make for NIH, and the research and development tax credit.

One item I read recently that is a little disturbing to me is that the research and development dollars by the

big pharmaceutical companies went up by 8 percent. That is good. It is good they are increasing their dollars for research and development. But did you know that their lobbying budget went up by 23 percent? Right now in this country, in this city, there are more lobbyists for the pharmaceutical industry than there are Members of Congress, and they have increased it another 23 percent. I am a little bit disturbed by that. My sense is, the only groups out there, as far as I know—maybe I am wrong; I have not seen anything to the contrary. As far as I know, the only groups out there opposed to reimporting safe drugs from Canada, FDA-approved drugs and FDA-approved facilities from Canada, the only group I know opposed to that is the pharmaceutical industry.

I read a recent story in the New York Times that said somewhere between $2 million and $2.5 million the pharmaceutical industry is giving out to research and policy organizations ''to build intellectual capital and generate a higher volume of messages from credible sources.''

We saw this happen many years ago with the tobacco industry. I give a little bit of caution here to the pharmaceutical industry. I hope they do not repeat some of what tobacco did that got them into so much trouble. Tobacco actually went out and funded sham research. They funded research that actually said tobacco was not harmful to their health when they knew it was and they had the research to say it was. They funded research to come out and say to the contrary, even though the research could not be validated. I certainly hope that is not what the pharmaceutical industry is doing today, but it sounds as if they are drifting in that direction.

It is definitely in the interest of the American public and of patients who need medical care in this country that we allow the safe importation of drugs from Canada. I think it will help people afford drugs, and it will help make drugs more affordable in this country.

As long as I am talking about the pharmaceutical industry, let me be very clear. I am proud of the pharmaceutical industry. I am proud of what they do. It is amazing some of the accomplishments we have achieved in medicine in the last 100 years. It is even more dramatic than the aeronautics industry. One hundred years ago, the Wright brothers launched at Kitty Hawk. Now, today, you know what we have been able to accomplish in the last 100 years.

The gains have been even more dramatic in the world of prescription drugs. It is amazing. It is critical for the United States to have an industry that is high tech, such as that industry, and that is on the cutting edge, is innovative, and is the world leader.

We want to try to be the leader in anything we can. I will continue to support NIH funding for research and development of prescription drugs. I think that is critical. I think that helps everybody. It is a win/win. It is not always cheap, but it is a win/win. It helps the industry. It helps the public. It helps medicine.

I will continue to support the tax credit for research and development. In fact, I am a cosponsor of a bill that will do that because I believe very strongly American business should have the incentive to invest in research and development because it helps the economy so much in the long term.

I see the prescription drug industry as in a little bit different category than most industries because they have a patent. The fact is that the Federal Government gives them a patent—another word for that would be a ''monopoly''—the Federal Government gives them a monopoly for a certain number of years to sell their drugs, but implicit in that monopoly is a public trust.

I think it is incumbent upon the people who hold those patents and the companies which hold those patents that they understand they have a special relationship with the public, because nothing less than the public's health is at stake.

Also, when I am looking at the pharmaceutical industry, I have to observe what Fortune Magazine came out with in the last I think it has been 3 or 4 years running now, that there are three different ways to measure the profitability of an industry. All three ways it is measured, the pharmaceutical industry by any standard is the most profitable industry in America.

The other thing about these companies is we talk about them as if they are our own companies but in fact many of them—maybe the majority, the big guys—are actually foreign corporations doing business in America. Most of these big companies are huge conglomerates that have different divisions and product lines. We need to remember most of these are global companies. They are doing research all over the world and they are selling these drugs all over the world, not just to the American marketplace. I think it is important we not segment the American marketplace at the expense of everything else.

I will talk about three of my experiences as attorney general for Arkansas. I know there are 49 other attorneys general who have had similar experiences, but these were important experiences I had with the pharmaceutical industry. Again, I am proud of the industry. I am very supportive of some of the things they do, but when I was attorney general we had one case where we found out they had secured a monopoly on certain key ingredients to two or three drugs. Without these key ingredients the drugs could not be made, and even the generic companies were buying these key ingredients from this one manufacturer. They purchased that manufacturer and before long, guess what, generic drugs went up because the name-brand company was jacking up the prices to the generics. That is not fair. That is not right. That is not allowing the marketplace to work in the way it should.

We had another case where a pharmaceutical company out and out lied about research. They told the Government they had tests that showed their name-brand product was better than the generic product. Another test came in later and showed they were absolutely the same. Unfortunately, for a number of years they were able to charge more for their product, much more than the generic, because people were convinced the generic was not as good.

When I was attorney general, we found there were a few companies that were playing games with the patent laws and with the FDA regulations and through various maneuvers they were able to extend the life of their patents and monopolies. Again, I did not come to name names and embarrass companies for some of the wrongdoings. I will be glad to visit with any Senator individually who would like to talk about these things. The pharmaceutical industry is a great industry overall. It does great things and I am very supportive of most of the things they do, but sometimes we have to call it like we see it. They do not always come into this debate with the cleanest of hands.

In my amendment, I am proposing a 2-year period of time in which to allow the Health and Human Services Department to establish their regulations in final form. I believe that is ample time. In fact, if it were up to me I would give them 30 days, but I think realistically they need time to verify and certify that the Canadian market is safe. I think they have actually been working on this since the year 2000. The fact the Dorgan amendment passed last week will really narrow their focus. Now that they only have to focus on Canada, I think that will help them quite a bit to bring veracity to these tests and to the marketplace.

Again, my proposal would not take effect if the regulations are finalized, and even if it does take effect in 2 years and then the regulations are finalized at a later time, mine immediately goes out of effect. What it would, in effect, do is make sure we are not paying more for drugs in America than they are in Canada. That is really not too much to ask, considering the U.S. Government will be far and away the largest purchaser of prescription drugs in the world.

The amendment says if the FDA has not implemented reimportation within 2 years of implementation of this law, it will become illegal for drug manufacturers to discriminate against American purchasers compared to our Canadian counterparts. Really, that is what it is all about. It is about price discrimination. I said a few moments ago it is about price gouging. If the prices are justified in Canada, then they are justified here, and we need to

make sure we get a price we are comfortable with.

In closing, I say that the consequences of not protecting American patients are too high. Uninsured patients cannot afford the prescription medicines they need today. Drug prices are fueling health care costs in a way we have seen on that previous chart. One thing we see time and time again is employers dropping health care coverage because they cannot afford prescription drugs. The skyrocketing drug costs have a tremendous potential to make the Medicare coverage we are considering erode significantly over time. What I mean by that is, as these deductibles go up, as the stop losses go up, as the gap in coverage widens, this proposed prescription drug benefit is going to make less sense over time because it is going to have so many problems.

Lastly, I want to show my colleagues this chart. We have seen bits and pieces of this already in this debate from last week, but in the first column this chart lists I believe it is nine of the most popular drugs in this country. It lists what they are used for. There are a lot of folks who are looking at this list and seeing big name-brand drug names. They probably use these drugs. Probably a lot of people in this Chamber use these drugs. This column shows what they are used for and then this third column is really critical. It is the U.S. price. It is what people pay in the U.S.

We are basing this on some Web sites. We know these are prices that can be charged here. This next column shows the price in Canada, what we know they can be charged there because we looked at Web sites that sell them. We can see the big difference on every single one of these nine drugs. The drug in Canada is much cheaper—in fact, 39 percent cheaper, 33 percent cheaper, on down the line. This one is 43 percent cheaper in Canada.

Bear in mind that a lot of these drugs are made in the very same plants. They are made in the very same places. One drug goes up to Canada and the other goes to Arkansas, Texas, Georgia, or wherever it may be. These are the very same drugs coming out of the very same plants. They meet all the same standards. In Canada, they are a lot cheaper.

What we are trying to do is get these prices in this column to go down to be a lot closer to the price in the Canadian column. It is not only good for the citizens but good for the taxpayers because as we add this prescription drug benefit we want to see these lower prices because that means tax dollars will go a lot further, and we, as a Nation, will be able to provide many more drugs through Medicare than we otherwise could.

I ask the Senate very respectfully to support this amendment to simply ensure Americans are treated fairly.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the pending amendments be set aside so the Senator from New Mexico can offer three amendments in sequence.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BINGAMAN. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. BINGAMAN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 984

Mr. BINGAMAN. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from New Mexico [Mr. BINGAMAN] proposes an amendment numbered 984.

Mr. BINGAMAN. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To carve out from payments to Medicare+Choice and MedicareAdvantage organizations amounts attributable to disproportionate share hospital payments and pay such amounts directly to those disproportionate share hospitals in which their enrollees receive care)

At the end of subtitle C of title II, add the following:

SEC. ___. CARVING OUT DSH PAYMENTS FROM PAYMENTS TO MEDICARE+CHOICE AND MEDICAREADVANTAGE ORGANIZATIONS AND PAYING THE AMOUNTS DIRECTLY TO DSH HOSPITALS ENROLLING MEDICARE+CHOICE AND MEDICAREADVANTAGE ENROLLEES.

(a) REMOVAL OF DSH PAYMENTS FROM CALCULATION OF ADJUSTED AVERAGE PER CAPITA COST.—

(1) UNDER MEDICARE+CHOICE.—Section 1853(c)(3) (42 U.S.C. 1395w–23(c)(3) and as amended by section 203) is amended—

(A) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (E)'',

(B) by adding at the end the following new subparagraph:

''(E) REMOVAL OF PAYMENTS ATTRIBUTABLE TO DISPROPORTIONATE SHARE PAYMENTS FROM CALCULATION OF ADJUSTED AVERAGE PER CAPITA COST.—For each year (beginning with 2004), the area-specific Medicare+Choice capitation rate under subparagraph (A)(ii) shall be adjusted to exclude from such rate the portion of such rate that the Secretary estimates is attributable to additional payment amounts described in section 1886(d)(5)(F) (treating hospitals reimbursed under section 1814(b)(3) as if such hospitals were reimbursed under section 1886).''.

(2) UNDER MEDICAREADVANTAGE.—Section 1853(a)(5) (as amended by section 203) is amended by adding at the end the following new subparagraph:

''(C) REMOVAL OF PAYMENTS ATTRIBUTABLE TO DISPROPORTIONATE SHARE PAYMENTS FROM CALCULATION OF ADJUSTED AVERAGE PER CAPITA COST.—For each year (beginning with 2004), the area-specific Medicare+Choice capitation rate under subparagraph (A)(ii) shall be adjusted to exclude from such rate the portion of such rate that the Secretary estimates is attributable to additional payment amounts described in section 1886(d)(5)(F) (treating hospitals reimbursed under section 1814(b)(3) as if such hospitals were reimbursed under section 1886).''.

(3) EFFECTIVE DATES.—The amendments made—

(A) by paragraph (1) shall apply to plan years beginning on and after January 1, 2004 and shall continue to apply to plan years beginning on and after January 1, 2006; and

(B) by paragraph (2) shall apply to plan years beginning on and after January 1, 2006.

(b) ADDITIONAL DSH PAYMENTS FOR MANAGED CARE ENROLLEES.—Section 1886(d)(5)(F) ((42 U.S.C. 1395ww(d)(5)(F)) is amended—

(1) in clause (ii), by striking ''clause (ix)'' and inserting ''clauses (ix) and (xvi)''; and

(2) by adding at the end the following new clause:

''(xvi)(I) For portions of cost reporting periods occurring on or after January 1, 2004, the Secretary shall provide for an additional payment amount for each applicable discharge of any subsection (d) hospital that is a disproportionate share hospital (as described in clause (i)).

''(II) For purposes of this clause the term 'applicable discharge' means the discharge of any individual who is enrolled under a risk-sharing contract with a eligible organization under section 1876 and who is entitled to benefits under part A and any individual who is enrolled with a Medicare+Choice organization or a MedicareAdvantage organization under part C.

''(III) The amount of the payment under this clause with respect to any applicable discharge shall be equal to the estimated average per discharge amount that would otherwise have been paid under this subparagraph if the individuals had not been enrolled as described in subclause (II).

''(IV) The Secretary shall establish rules for paying an additional amount for any hospital reimbursed under a reimbursement system authorized under 1814(b)(3) if such hospital would qualify as a disproportionate share hospital under clause (i) were it not so reimbursed. Such payment shall be determined in the same manner as the amount of payment is determined under this clause for disproportionate share hospitals.''.

Mr. BINGAMAN. Mr. President, this amendment deals with the issue of safety net hospitals. That is a label we have put on what are, in fact, called in the law Medicare disproportionate share hospitals, or DSH. The payments we make for DSH are intended to support these safety net hospitals. By adopting my amendment, we ensure we are not unintentionally reducing the payments to these safety net hospitals.

By ''safety net hospitals,'' in general terms, we are talking about hospitals that provide medical services to a great many individuals who do not have health care coverage. That is where the phrase ''disproportionate share'' comes from, saying they have a disproportionate share of the uninsured coming to their hospitals seeking medical treatment. We have set up a system through Medicare and also a separate system through Medicaid to provide additional funds to those safety net hospitals.

Since DSH payments are made as add-on adjustments to fee-for-service

reimbursements, those payments to hospitals are reduced as Medicare beneficiaries choose to enroll in private health plans and the money is instead logically wrapped into payments by the Federal Government to the private health plans.

We had some testimony before the Finance Committee. Tom Skully testified that he estimates enrollment in private health plans will increase from 10 percent, where it is today, up to 43 percent by the year 2008. Tom Skully, of course, is in charge of administering these programs. His opinion is extremely important in this debate.

If he is right, that would result in an average reduction in the Medicare DSH payments—that is, the payments to the safety net hospitals—of about 37 percent. Clearly, this is not the intent of Congress in this legislation. We are not setting out in this legislation, which is intended to provide a prescription drug benefit to seniors, to intentionally reduce the payments to safety net hospitals. The bill itself, in fact, increases DSH payments to rural safety net hospitals. That is a provision Chairman Grassley and the ranking member, Senator BAUCUS, and I very strongly support.

The Medicare Payment Advisory Commission, which advises the Congress on Medicare policy, has said in their report ''plans are overpaid''—private plans, they are talking about—''to the extent they do not pass on DSH payments to the appropriate hospitals.''

Congress recognized this program in the past and intentionally carved out graduate medical education, or GME, payments from health plans and made provisions so those payments would go directly to the teaching hospitals. That policy is included in S. 1, but unfortunately the disproportionate share payments were not addressed in the underlying bill.

Also, in the case of Medicaid, Congress required a carve-out of DSH payments under Medicaid to health plans in 1997 when Congress authorized the substantially greater use of managed care in the Medicaid Program. The intent was clear, that Congress did not want to unintentionally harm the safety net hospitals as they had more people move into Medicaid managed care.

We are essentially trying to do the very same thing here. The same recognition and the same policy should apply in the case of Medicare DSH payments that we applied in the case of Medicaid DSH payments.

Our Nation's important public hospitals lost an estimated $527 million in treating Medicare patients in the year 2001. That was with 88 percent of those public hospitals reporting losses on Medicare. They cannot afford additional Medicare cuts. That would be exactly what we would be enacting if we passed the underlying bill without including the amendment I provide here. Now is the time to protect and carve out the amendments intended to go to safety net hospitals to ensure they actually do go to the safety net hospitals even once this program is put in place.

I hope very much my colleagues will support this amendment. I hope it can be adopted and included in the legislation before it passes the Senate.

AMENDMENT NO. 972

Mr. President, I have another amendment numbered 972, and I ask unanimous consent that the pending amendment be set aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report.

The legislative clerk read as follows:

The Senator from New Mexico [Mr. BINGAMAN] proposes an amendment numbered 972.

Mr. BINGAMAN. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To provide reimbursement for Federally qualified health centers participating in medicare managed care)

At the end of title VI, insert the following:

SEC. ___. REIMBURSEMENT FOR FEDERALLY QUALIFIED HEALTH CENTERS PARTICIPATING IN MEDICARE MANAGED CARE.

(a) REIMBURSEMENT.—

(1) IN GENERAL.—Section 1833(a)(3) (42 U.S.C. 1395*l*(a)(3)) is amended to read as follows:

''(3) in the case of services described in section 1832(a)(2)(D)—

''(A) except as provided in subparagraph (B), the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items and services described in section 1861(s)(10)(A)) exceed 80 percent of such costs; or

''(B) with respect to the services described in clause (ii) of section 1832(a)(2)(D) that are furnished to an individual enrolled with a MedicareAdvantage plan under part C pursuant to a written agreement described in section 1853(j), the amount by which—

''(i) the amount of payment that would have otherwise been provided under subparagraph (A) (calculated as if '100 percent' were substituted for '80 percent' in such subparagraph) for such services if the individual had not been so enrolled; exceeds

''(ii) the amount of the payments received under such written agreement for such services (not including any financial incentives provided for in such agreement such as risk pool payments, bonuses, or withholds),

less the amount the Federally qualified health center may charge as described in section 1857(e)(3)(C);''.

(b) CONTINUATION OF MEDICAREADVANTAGE MONTHLY PAYMENTS.—

(1) IN GENERAL.—Section 1853 (42 U.S.C. 1395w–23), as amended by this Act, is amended by adding at the end the following new subsection:

''(j) PAYMENT RULE FOR FEDERALLY QUALIFIED HEALTH CENTER SERVICES.—If an individual who is enrolled with a MedicareAdvantage plan under this part receives a service from a Federally qualified health center that has a written agreement with such plan for providing such a service (including any agreement required under section 1857(e)(3))—

''(1) the Secretary shall pay the amount determined under section 1833(a)(3)(B) directly to the Federally qualified health center not less frequently than quarterly; and

''(2) the Secretary shall not reduce the amount of the monthly payments to the MedicareAdvantage plan made under section 1853(a) as a result of the application of paragraph (1).''.

(2) CONFORMING AMENDMENTS.—

(A) Paragraphs (1) and (2) of section 1851(i) (42 U.S.C. 1395w–21(i)(1)), as amended by this Act, are each amended by inserting ''1853(j),'' after ''1853(i),''.

(B) Section 1853(c)(5) is amended by striking ''subsections (a)(3)(C)(iii) and (i)'' and inserting ''subsections (a)(3)(C)(iii), (i), and (j)(1)''.

(c) ADDITIONAL MEDICAREADVANTAGE CONTRACT REQUIREMENTS.—Section 1857(e) (42 U.S.C. 1395w–27(e)) is amended by adding at the end the following new paragraph:

''(3) AGREEMENTS WITH FEDERALLY QUALIFIED HEALTH CENTERS.—

''(A) PAYMENT LEVELS AND AMOUNTS.—A contract under this part shall require the MedicareAdvantage plan to provide, in any contract between the plan and a Federally qualified health center, for a level and amount of payment to the Federally qualified health center for services provided by such health center that is not less than the level and amount of payment that the plan would make for such services if the services had been furnished by a provider of services that was not a Federally qualified health center.

''(B) COST-SHARING.—Under the written agreement described in subparagraph (A), a Federally qualified health center must accept the MedicareAdvantage contract price plus the Federal payment provided for in section 1833(a)(3)(B) as payment in full for services covered by the contract, except that such a health center may collect any amount of cost-sharing permitted under the contract under this part, so long as the amounts of any deductible, coinsurance, or copayment comply with the requirements under section 1854(e).''.

(d) SAFE HARBOR FROM ANTIKICKBACK PROHIBITION.—Section 1128B(b)(3) (42 U.S.C. 1320a–7b(b)(3)) is amended—

(1) in subparagraph (E), by striking ''and'' after the semicolon at the end;

(2) in subparagraph (F), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following new subparagraph:

''(G) any remuneration between a Federally qualified health center (or an entity controlled by such a health center) and a MedicareAdvantage plan pursuant to the written agreement described in section 1853(j).''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to services provided on or after January 1, 2006, and contract years beginning on or after such date.

Mr. BINGAMAN. As we proceed with this consideration of S. 1—and I believe firmly that it will be passed through the Senate this week—we need to be very careful not to create unintended consequences as a result of our legislation.

The previous amendment I discussed tries to head off some unintended and certainly undesirable consequences for safety net hospitals. This amendment tries to do the very same thing with regard to community health centers. Let me explain what this amendment does.

First, I am concerned about the implications that passing this underlying legislation as it now is pending in the Senate could have on the Nation's community health centers. Community health centers have enjoyed broad bipartisan support in Congress. They have enjoyed strong support from the President. The President and the Congress have committed to doubling the funding for community health centers over a 5-year period. That is an encouraging development. Health centers provide care to over 13 million people annually, nearly 1 million of whom are low-income Medicare beneficiaries. They receive section 330 Federal Public Health Service Act grant funds to support care for the uninsured and for low-income patients.

To ensure that those grant dollars are spent for the purposes intended, Congress has specifically taken action to ensure that both Medicare and Medicaid are fully reimbursing the health centers for the costs associated with the care those health centers provide to Medicare and Medicaid beneficiaries.

Simply put, funding intended for low-income and uninsured people should not be diverted and used to subsidize Medicare underpayments. Therefore, health centers are reimbursed by Medicare under a cost-based system.

The amendment I am offering, amendment No. 972, would simply extend this same requirement to the new Medicare Advantage Programs by ensuring that community health centers are provided with a wraparound, or a supplemental payment equal to the difference between the payments they now receive under Medicare generally and the payments they would receive from Medicare Advantage plans.

This concept is not new. In 1997, when Congress allowed States to dramatically increase the number of patients enrolled in Medicaid managed care, we recognized the potential impact on community health centers, and we required the Medicaid Program to provide this wraparound, or supplemental payment, for the difference between the managed care organization's payment and the health center's reasonable cost. We need to do the same thing here, with my amendment, in the Medicare Program.

According to testimony, again, from Tom Scully, which I referred to just a minute ago, the hearing we had in the Finance Committee indicated there are widely differing estimates for how many Medicare beneficiaries would actually enroll in private health plans. Those estimates range from 9 percent to 43 percent, a fivefold difference.

Dr. Holtz-Eakin's words were that:

These are honest differences in trying to read a very uncertain future.

All of us want to reduce that uncertainty. If Mr. Scully is correct, then health centers will lose their guarantee of cost-based reimbursement to 43 percent of their Medicare patients, and that potentially will result in centers having to dip into their Federal grant funds, which is money that was intended to provide care to the uninsured to make up for losses to their Medicare patients.

The Nation's safety net is already a fragile one. We should take this action. We should adopt this amendment to ensure we are not jeopardizing that safety net even further by passing the underlying legislation without the amendment.

Again, this Congress and the President have made a commitment to these community health centers to deal with the growing number of uninsured in the country. In light of this, the amendment is, in my view, vital to the health of these health centers and ensuring the health centers are not forced to decide whether to subsidize the Medicare Program with their grant dollars or refuse to provide services to the 1 million Medicare beneficiaries to whom they currently provide those services.

Just as I indicated with the previous amendment, I think this will substantially improve the bill. I urge my colleagues to support this amendment, and I hope, when we come to consideration of it and a vote on it, that the Senate will endorse this amendment. It will avoid a consequence that I know is not intended by any of my colleagues here in the Senate.

I ask this amendment I have just been discussing, amendment No. 972, be set aside so I may off another amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 973

Mr. BINGAMAN. Mr. President, I ask amendment No. 973 be called up for immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from New Mexico [Mr. BINGAMAN], proposes an amendment numbered 973.

Mr. BINGAMAN. I ask unanimous consent the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To amend title XVIII of the Social Security Act to provide for the authorization of reimbursement for all medicare part B services furnished by certain Indian hospitals and clinics)

At the end of subtitle B of title IV, insert the following:

SEC. ___. AUTHORIZATION OF REIMBURSEMENT FOR ALL MEDICARE PART B SERVICES FURNISHED BY CERTAIN INDIAN HOSPITALS AND CLINICS.

(a) IN GENERAL.—Section 1880(e) (42 U.S.C. 1395qq(e)) is amended—

(1) in paragraph (1)(A), by striking ''for services described in paragraph (2)'' and inserting ''for all items and services for which payment may be made under such part'';

(2) by striking paragraph (2); and

(3) by redesignating paragraph (3) as paragraph (2).

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after October 1, 2004.

Mr. BINGAMAN. Mr. President, this amendment deals with Indian Medicare Part B services. The Indian Health Service, of course, operates hospitals and clinics in various parts of the country, several in my State. Those hospitals and clinics provide health care to American Indians on or near reservations and to Alaska Natives. In many cases, those are hospitals and clinics that currently are unable to bill for all of the Medicare Part B services they are providing. In effect, the Indian Health Service under current law is subsidizing the Medicare Program because those services which would otherwise be paid for by Medicare, if it were a different provider other than the Indian Health Service—are having to be paid by the Indian Health Service itself.

I think we in the Senate are all aware that the Indian Health Service, year after year, has been substantially underfunded. In 2000, Indian Health Service hospitals and clinics were made eligible for services of physicians and certain other practitioners, but there were real limits put on the services that were provided. Specifically, they were denied payment, the Indian Health Service hospitals and clinics were denied payment for the following important items that I will call to the attention of my colleagues so they may realize what the Indian Health Service is not permitted to be reimbursed for in the current law: Durable medical equipment. This includes such items as wheelchairs, as well as blood testing strips, blood monitors for diabetes patients—which is a severe problem among Native Americans throughout this country.

The second item is home and some institution dialysis supplies and equipment. Since the prevalence of diabetes in the Native-American population and among Alaska Natives is three times the rate in the general U.S. population, Indian people experience a high rate of renal disease, including end-state renal disease. Clearly these are expenses, these are supplies, this is equipment that should be reimbursed.

Third, cancer screening.

Next, Pap smears, glaucoma screening, clinic and hospital-based ambulance services, prosthetic devices, covered vaccines, including hepatitis B, pneumococcal and influenza, chemotherapy and antigen drugs, and clinical laboratory services.

The amendment I am offering would simply make these Indian health facilities and providers eligible for payment for all of the Part B Medicare-covered items, and individuals, to the same extent other providers are eligible for payment for those supplies and services.

The amendment assures that Native Americans would have the same access to health services as any other American. If the Indian Health Service providers are unable to bill for those services, as they currently are, then the Indian Health Service budget shortfalls

wind up resulting in the rationing or delaying of treatment to many of our Native-American citizens. For some of these individuals, it means going out of the Indian Health Service system in order to get more prompt service because other providers, in fact, do get reimbursed and can get reimbursed on Medicare for providing those services.

Native Americans and Indian Health Service providers should not be subject to such barriers to care and to payment. Similarly, they should not be subject to such complexity as they are only prohibited from billing and receiving payment for certain services and not for others.

It needs to be noted that the Medicare Advantage payments are based in part on fee-for-service expenditures in the defined region. For those areas with large numbers of Native Americans—such as my State—payment rates are skewed downward if the Indian Health Service providers are unable to bill appropriately for the full range of services. We have lower reimbursement rates for Medicare in my State than many of the surrounding areas. One of the factors—not the only one, but one of the factors that is causing that is this problem I am trying to address with the amendment, the problem that the Indian Health Service is unable to be reimbursed. Accordingly, the amount Medicare is paying is skewed downward. Accordingly, that affects Medicare payments throughout the region.

There is absolutely no policy rationale for limiting the payment to the Indian Health Service hospitals and clinics for only certain of the Medicare Part B services.

I urge the Senate to end this unfortunate discrimination that has been built into the statutes under which we currently operate.

I hope, again, this amendment will be favorably acted upon by the Senate when it comes to a vote. I believe it will substantially improve the legislation and will correct an inequity that is in current law that needs to be corrected.

AMENDMENT NO. 933

Mr. President, let me at this point move to another amendment. We do not need to move off the current amendment, but I wish to discuss a different amendment that is pending that I am not calling up for a vote at this time but one I offered sometime earlier.

The amendment I wish to speak about briefly now relates to the assets test. It is a proposal I have made to repeal the assets test.

First, I compliment Chairman GRASSLEY and the ranking member, Senator BAUCUS, for making significant progress and improvement with respect to the low-income benefit as compared to similar legislation that was considered last year. The bill, although improving the low-income benefit and reducing the impact of the assets test, still leaves in place an assets test of just $4,000 for an individual and $6,000 for a couple.

This assets test has two very important consequences. By explaining these consequences, I think I will be able to explain what I mean by an ''assets test.''

First of all, for those who have incomes below the poverty level, if you own as much as $4,100 in a whole range of different assets combined—it can be savings accounts, bonds, savings bonds, burial plots, insurance policies, a car, the net worth of your car, livestock, whatever you happen to own—if the combined value of these categories adds up to $4,100, then your cost sharing under the bill increases and you do not get the full benefit of this low-income prescription drug benefit we are talking about as part of this legislation.

Your cost sharing under the bill increases by 400 percent if you fail this assets test compared to similarly situated low-income people. If your income is between 100 and 135 percent of poverty, then the assets test increases cost sharing by 200 percent; that is, you have to pay twice as much if, in fact, your total assets add up to more than $4,100.

The result is, Congress has effectively established a policy that encourages low-income seniors or people with disabilities to further impoverish themselves—that is, dispose of their property, sell their property off—in order to get the full benefit that is advertised.

What kind of sense does this really make, to ask low-income and vulnerable seniors and people with disabilities to get rid of the very minimal savings they have in order to get the full low-income benefit?

Let me talk about the other aspect of this that I think is particularly significant and needs to be discussed here. I think more and more, as people have been reading this legislation—this legislation goes on for more than 600 pages, so anyone who thinks we are doing something simple here by just giving people a prescription drug benefit has not spent the time to try to understand this legislation and read it.

One of the aspects of the assets test that is most troublesome is the enormously cumbersome and bureaucratic procedure we put in place that affects so many of our low-income seniors who want to benefit from this prescription drug benefit we are adding. Also, there is a very substantial invasion of people's lives involved. Let me explain that in a little more detail.

Any of you who do not think this is a complex, cumbersome, bureaucratic process we are setting up for low-income seniors, I urge you to just read the Pennsylvania 16-page application for low-income Medicare beneficiaries who want to qualify for assistance with premiums and copayments and deductibles that will also be the basis for qualifying for the low-income benefit in this bill. I question whether many of us in Congress would be able to fill out that application.

What I have on this easel is not the Pennsylvania 16-page application. This is a much shorter, so-called streamlined 4-page application from the State of Ohio.

To comply with the assets test requirement, as shown on this chart, in the State of Ohio they ask you to detail in this form all that you own in an enormous number of categories. Let me just go through this: your savings accounts, your checking accounts, anything you have with a credit union, any promissory notes, any stocks and bonds, any tax shelter accounts, any certificates of deposit, automobiles, 401(k)s, trust funds, Christmas clubs, vehicles of any kind other than an automobile—if you happen to have a pickup—money market funds, life insurance, land contracts, IRAs, Keogh plans, revocable burial accounts, irrevocable burial accounts, and other assets.

So if you own a cow or you own a horse, whatever you own, they want to know about it. Then they add up the total value of those assets to see whether you have $4,100 there. If you do have $4,100 there, you have just failed the assets test.

There are some 20 items here for low-income seniors or disabled Medicare beneficiaries to report just to apply for the prescription drug low-income benefit. It is a test, as I indicated, which many of us in Congress would have trouble passing without the assistance of a lawyer or an accountant. It is a major barrier, it is a burden we are imposing on these very individuals whom we say we are trying to help.

I bring this to the attention of the Senate because I do not think many of us know the extent to which these applications are both difficult—difficult to complete—and also a terrible invasion of privacy.

The Georgia application reads—and let me put that provision on the easel. We have a blowup of the application, which I am sure very few can read. But just to make the point, we have tried to blow it up so people can see it. I will read from the Georgia application. It says:

> I understand that, by signing this application, I am agreeing to a full investigation or review of my eligibility by state and/or federal officials. This may include inquiries of employers, medical providers, financial institutions, and other business and professional persons and review of any agency records.

Oklahoma's application goes even further. It reads:

> I authorize the release of any necessary information, documents, or forms to the [Oklahoma department] from individuals, businesses, schools, banking institutions, data brokers, public or private organizations, Oklahoma state agencies, including personal and/or business income tax returns from the Oklahoma Tax Commission, or federal agencies to determine my eligibility for assistance or to determine the accuracy of any payments to vendors on my behalf.

The Pennsylvania application—unfortunately, I do not have that blown up here; it would take more easels than we have available—requires the applicant to consent to:

. . . fully cooperate in the finger, photo, and signature imaging process.

It requires the reporting of any changes in the number of people in the household, any changes in the resources of the individual, and it adds—and this is a quotation from the report; this is the Pennsylvania report—''you must report any plans to leave the state, even temporarily.'' So if you want to come from Pennsylvania down to Washington, DC, to see your Senator, you have to notify the folks in Pennsylvania that you are leaving the State if you are, in fact, eligible for this benefit.

The burden of the application ought to be something that would scare off a lot of individuals. Here is a line that is in the application of many States:

State and Federal law provides for fine, for imprisonment, or both for any person who withholds or gives false information—

I note that it does not include anything about intentionally giving false information.

in order to obtain assistance to which he or she is entitled.

The application from Georgia reads:

I understand the questions on this application—

which I would attest is virtually impossible for a lot of folks unless they do get professional help in understanding all of this—

and I certify under penalty of perjury that the information given by me on this form is correct and complete to the best of my knowledge.

The result of this assets test, this barrage of paperwork presented to people when they come in and ask for the benefits, is what the Congressional Budget Office is telling us. Their estimate is that only 50 percent of Medicare beneficiaries who are eligible for the low-income benefit under this bill will actually get the benefit. I find it shocking, after reading these applications, that the number could even be that high. It is a testament to the Nation's seniors and disabled that so many people go through the bureaucratic maze to get the benefit we are talking about.

On the implementation of the Children's Health Insurance Program—a different program but one that also had a similar assets test—a number of States initially imposed assets tests on the families before they allowed children to get health care coverage. Over time most of those States have repealed those tests.

Our experience with the assets test in the case of the Children's Health Insurance Program should be instructive. The Denver Post wrote at the time:

It seems the system is penalizing people for trying to build better lives. The message is that you must stay poor. If you have a decent running car that will get you to where you need to go, you will lose your health care coverage.

The Rocky Mountain News added:

Jumping through the hoops might be a whole lot easier for some families than filling out the required forms which rival the renowned handiwork of the Internal Revenue Service for clarity and ease of compliance. The logic of erecting such paperwork obstacles escapes us. Government doesn't have to offer insurance to the children of working poor but having made the decision to do so, it is hardly fair then to smother the program beneath layers of red tape.

These last two quotes relate to the Children's Health Insurance Program, not to the Medicare prescription drug benefit. But the same problem pointed out when we had the assets test applied in the case of the Children's Health Insurance Program is true and exists with respect to this prescription drug coverage for our Nation's low-income elderly and disabled citizens. We are not only smothering them beneath layers of red tape, but the applications threaten their privacy and further threaten fines or imprisonment if those individuals who apply provide false information even if it is unintentional in some cases.

I raise these points because very few, if any, Senators have taken the time to understand the application process, and they would be appalled if they really did take the time to understand the difficulties we are placing in the way of a senior getting access to this low-income benefit. I urge each of them to attempt to fill out their own State's application. Clearly that would be a good way to acquaint themselves with the difficulty of the problem we are putting in the way of people.

Before closing, let me point out the assets test was established in 1988. It has never been updated for inflation. Nor does the bill update the assets test for inflation.

Not only was the assets test established in 1988 at this level of $4,000 and $6,000 per couple, and it has never been updated for inflation, but it has built in it a marriage penalty. If you get married, a couple can only have a combined net worth of $6,000. If you remain single, you can have a net worth of $4,000. Everyone who gives speeches about the importance of eliminating the marriage penalty will want to support the amendment for that reason.

The bill does update the amount of the deductible. The amount of the deductible increases. It does update the catastrophic limit by an inflation factor pegged to increases in drug spending which the Congressional Budget Office estimates will increase on average 12 percent a year over the next 10 years. But we do nothing to index or update the amount of this assets test.

While I completely respect the position of the chairman that he would place a priority on using any additional funds to close the coverage gap in the bill—I certainly favor closing that coverage gap myself—we need to protect our Nation's most vulnerable, the poorest and the sickest among us first. If we provide a low-income benefit, as the bill does, it should be unacceptable to us to have only half of those who are eligible for that benefit actually access the benefit. This is similar to the Children's Health Insurance Program in that we are not required to provide this benefit, but now that we are choosing to do so and we are choosing to do so on a bipartisan basis, we need to be sure those who are intended to benefit from it can in fact do so. We are about to impose on these individuals an avalanche of bureaucratic red tape when they try to access the benefit.

The underlying legislation has contained in it 69 pages of language that is designed to give health care providers a whole range of regulatory relief. Here we have some of that detail on this chart. The appeals process is being reformed—expedited review procedures, provider ombudsman, a variety of things to try to help providers. But we have nothing to give beneficiaries any relief from the burden I have described.

One Senator said last week that the amendment I have offered to eliminate the assets test would cost money. It would increase State administrative costs. Frankly, that statement could not be more inaccurate. In fact, if we dramatically reduce the paperwork burden, the bureaucratic paperwork, States would not have to increase administrative costs. They would actually be able to reduce those costs. It is not the amendment that is increasing these costs. It is the underlying bill. It is not the amendment that is imposing the burden upon States. It is the underlying bill itself.

All the amendment does is significantly reduce the amount of bureaucratic paperwork that must be dealt with in order for this benefit to be provided. Some States have actually found that it costs more to administer the assets test than they save by disqualifying people who fail the test.

In addition, Senator HATCH's comments on the amendment were right in saying it would increase costs. But the estimate is that it would increase costs by $4 billion over the 10-year period for which the Congressional Budget Office calculates.

This is well within the budget limitations Congress established for this drug benefit. There are $19.3 billion remaining in the budget for fiscal years 2009 through 2013. My amendment provides those are the years that this assets test would be eliminated.

The amendment also does so by eliminating the false advertising we are engaged in as we tout a low-income benefit when, in fact, only 50 percent of eligible beneficiaries are going to receive it. In fact, CBO estimates that another 1 million low-income seniors who are eligible for this low-income benefit will in fact be able to access it if this amendment is adopted.

If we eliminate the bureaucratic redtape, who are the 1 million people who would benefit from this assets test? The Commonwealth Fund has studied that. They have said in a recent report:

Compared to other Medicare beneficiaries, low-income Medicare beneficiaries are older,

they are more likely to be women, they are more likely to be single, and more than twice as likely to be widowed or divorced or separated. Low-income Medicare beneficiaries are almost twice as likely to report that their health is either fair or poor.

I think it is these people who need to be our first priority. The amendment I have to eliminate the assets test will help us to provide a genuine benefit to these people. I hope my colleagues will support this effort. It will substantially improve the underlying bill and substantially simplify the providing of this benefit we are all hoping occurs.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, I thank the Senator from New Mexico. I think he has a very good point. The current assets test is degrading, unworkable. It is just not good policy. It is also extremely complicated. Currently, assets tests apply to various kinds of benefits—sometimes Medicaid or Medicare, or certain categories of Medicare. It defies logic, it is so complicated. Frankly, if this Senator had his way, we would repeal a lot of the assets tests which have not been updated for a good number of years—since 1987 or 1989. We are talking about $9,000 a year or something like that. On the other hand, we are dealing with $400 billion in this bill. A total repeal of the assets test on drugs only would be—I don't know the cost, but it would be expensive.

The Senator from New Mexico, in his good-faith effort to try to deal with unnecessary complications—which is bad public policy—is trying to modify a repeal of the assets test to a smaller category. Frankly, it has a lot of appeal. But as the Senator knows very well, probably as well if not better than most Members of this body, that would only go part way toward correcting some of the inequities caused by the assets test. Even if the Senator's amendment to totally repeal the asset test applying to drugs would go into effect, nevertheless, the asset test with respect to the rest of the categories would still apply under Medicare. That is low-income categories that are mandatory.

It is incredibly complex, which is to say I am very sympathetic with the Senator and I am hopeful we get this score back from CBO on the Senator's asset test amendment, that it is one that certainly can work within the $400 billion limit we are operating under. I, for one, believe it should pass. I thank the Senator very much for persistently and very forthrightly, with a lot of good information, bringing this up to be dealt with.

Mr. President, I ask unanimous consent that all pending amendments be temporarily laid aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 985

Mr. BAUCUS. On behalf of Senator EDWARDS, I send an amendment to the desk with respect to consumer advertising.

The PRESIDING OFFICER. The clerk will report the amendment.

The assistant legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS], for Mr. EDWARDS, himself, and Mr. HARKIN, proposes an amendment numbered 985.

Mr. BAUCUS. Mr. President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To strengthen protections for consumers against misleading direct-to-consumer drug advertising)

At the end, add the following:

TITLE ____—DIRECT-TO-CONSUMER PRESCRIPTION DRUG ADVERTISING

SEC. ___01. HEAD-TO-HEAD TESTING AND DIRECT-TO-CONSUMER ADVERTISING.

(a) NEW DRUG APPLICATION.—Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) is amended—

(1) in subparagraph (A) of the second sentence of subsection (b)(1), by inserting before the semicolon at the end the following ''(including whether the drug is safe and effective for use in comparison with other drugs available for substantially the same indications for use prescribed, recommended, or suggested in the labeling proposed for the drug)''; and

(2) in subsection (d)(5)—

(A) by inserting ''(A)'' after ''will''; and

(B) by inserting after ''thereof'' the following: '' or (B) offer a benefit with respect to safety, effectiveness, or cost (including effectiveness with respect to a subpopulation or condition) that is greater than the benefit offered by other drugs available for substantially the same indications for use prescribed, recommended, or suggested in the labeling proposed for the drug''.

(b) MISBRANDING.—Section 502(n)(3) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 352(n)(3)) is amended by inserting after ''effectiveness'' the following: ''(including effectiveness in comparison to other drugs for substantially the same condition or conditions)''.

(c) REGULATIONS.—

(1) IN GENERAL.—Not later than 180 days after the date of enactment of this Act, the Secretary of Health and Human Services shall promulgate amended regulations governing prescription drug advertisements.

(2) CONTENTS.—In addition to any other requirements, the regulations under paragraph (1) shall require that—

(A) any advertisement present a fair balance, comparable in depth and detail, between—

(i) information relating to side effects and contraindications; and

(ii) information relating to effectiveness of the drug (including effectiveness in comparison to similar drugs for substantially the same condition or conditions);

(B) any advertisement present a fair balance between—

(i) aural representations and visual representations (such as large-print or full-screen text) relating to side effects and contraindications; and

(ii) aural representations and visual representations relating to effectiveness of the drug (including effectiveness in comparison to similar drugs for substantially the same condition or conditions);

(C) prohibit false or misleading advertising that would encourage a consumer to take the prescription drug for a use other than a use for which the prescription drug is approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355); and

(D) require that any prescription drug that is the subject of a direct-to-consumer advertisement include in the package in which the prescription drug is sold to consumers a medication guide explaining the benefits and risks of use of the prescription drug in terms designed to be understandable to the general public.

SEC. ___02. CIVIL PENALTY.

Section 303 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 333) is amended by adding at the end the following:

''(h) DIRECT-TO-CONSUMER PRESCRIPTION DRUG ADVERTISING.—

''(1) IN GENERAL.—A person that commits a violation of section 301 involving the misbranding of a prescription drug (within the meaning of section 502(n)) in a direct-to-consumer advertisement shall be assessed a civil penalty if—

''(A) the Secretary provides the person written notice of the violation; and

''(B) the person fails to correct or cease the advertisement so as to eliminate the violation not later than 180 days after the date of the notice.

''(2) AMOUNT.—The amount of a civil penalty under paragraph (1)—

''(A) shall not exceed $500,000 in the case of an individual and $5,000,000 in the case of any other person; and

''(B) shall not exceed $10,000,000 for all such violations adjudicated in a single proceeding.

''(3) PROCEDURE.—Paragraphs (3) through (5) of subsection (g) apply with respect to a civil penalty under paragraph (1) of this subsection to the same extent and in the same manner as those paragraphs apply with respect to a civil penalty under paragraph (1) or (2) of subsection (g).''.

SEC. ___03. REPORTS.

The Secretary of Health and Human Services shall annually submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report that, for the most recent 1-year period for which data are available—

(1) provides the total number of direct-to-consumer prescription drug advertisements made by television, radio, the Internet, written publication, or other media;

(2) identifies, for each such advertisement—

(A) the dates on which, the times at which, and the markets in which the advertisement was made; and

(B) the type of advertisement (reminder, help-seeking, or product-claim); and

(3)(A) identifies the advertisements that violated or appeared to violate section 502(n) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 352(n)); and

(B) describes the actions taken by the Secretary in response to the violations.

SEC. ___04. REVIEW OF DIRECT-TO-CONSUMER DRUG ADVERTISEMENTS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall expedite, to the maximum extent practicable, reviews of the legality of direct-to-consumer drug advertisements.

(b) POLICY.—The Secretary of Health and Human Services shall not adopt or follow any policy that would have the purpose or effect of delaying reviews of the legality of direct-to-consumer drug advertisements except—

(1) as a result of notice-and-comment rulemaking; or

(2) as the Secretary determines to be necessary to protect public health and safety.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the amendment be temporarily laid aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 986

Mr. BAUCUS. Mr. President, I send to the desk an amendment on behalf of Senator LAUTENBERG with respect to moving the effective date of this legislation 1 year forward.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS], for Mr. LAUTENBERG, for himself, Mr. REED, Mrs. CLINTON, and Mr. CORZINE, proposes an amendment numbered 986.

Mr. BAUCUS. Mr. President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To make prescription drug coverage available beginning on July 1, 2004)

At the end of title I, insert the following:

SEC. __. IMPLEMENTATION OF TITLE.

Notwithstanding any other provision of this Act, the amendments made by this title shall be implemented and administered so that prescription drug coverage is first provided under D of title XVIII beginning on July 1, 2004.

Mr. BAUCUS. Mr. President, those are two amendments which Senators have offered. That means, as a practical consequence, that they are more likely to be considered than amendments that have not been offered. These are amendments that I will now call CBO and get scores on. It is difficult to get scores from CBO on amendments if they are not pending. If Senators have not told me they are going to offer amendments, I cannot put them on the list. This is a roundabout way of saying to Senators who wish to offer amendments, it behooves them to do it now and get them into the queue. Then I can call CBO and tell them we need a score on this or that amendment. CBO cannot score all amendments that will be potentially filed, because it has limited resources. It can only do it as they become real. I urge Senators to come forward with amendments so we can deal with them.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. SANTORUM. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. BURNS). Without objection, it is so ordered.

AMENDMENT NO. 981

Mr. SANTORUM. Mr. President, I rise in opposition to the Pryor amendment which I understand was debated just a few minutes ago. I do so in strongest terms. We had a debate last week on the issue of reimportation of drugs from Canada. The Senate spoke and said that if the Secretary of Health and Human Services would declare that such reimportation was safe, we could then bring these drugs across the border at a reimported price.

Many on this side of the aisle, and I am sure a few on the other side of the aisle, voted for that amendment, as amended, by Senator COCHRAN for that safety measure basically concluding that the Health and Human Services Secretary would never determine that these drugs would be considered safe, since the Canadian Government itself said they could not guarantee they were safe. We have all sorts of problems today with counterfeit drugs, drugs getting shipped in from other countries, leading to a variety of health problems. There was a great amount of comfort.

The Pryor amendment goes one step further, according to my understanding, saying if the Secretary does not say the drugs are safe within a period of time—I believe it is 2 years—then prices of drugs in this country will be set by the Canadian Government, which I find a startling concession of authority of this Government to a foreign country; that we are going to have a foreign country and a board in a foreign country set prices for drugs in the United States of America.

It is a remarkable concession for the Senate. I know we have a great desire to control many things in the United States. We would like to set prices, I am sure, on lots of different items. We do it in the Agriculture bill all the time. Now we are going one step further. If you cannot win price controls by having the Senate pass a price control bill, delegate the Canadian Government to control the prices for you.

Maybe we should choose different countries. Why Canada? Maybe there are other countries that set even lower prices than Canada. I suspect there are countries that would set lower prices than Canada. Why not choose them if we really want to save consumers money?

If this amendment is adopted, I would probably offer amendments that we should have chicken prices set by the Canadian Government, wheat prices set by the Canadian Government, and lumber and timber prices set by the Canadian Government. Maybe it would just be good to have the Canadian Government set all our prices in this country for those items we think are important. Obviously, they are very thoughtful in Canada, and they know what is best for us here, and we should just go ahead and let them set our prices for us.

We are not talking about the Canadian marketplace setting prices. We are talking about the Canadian Government. Let me explain how the Canadian Government operates. The Canadian Government operates as follows: You want to sell your drug in Canada? Fine, you have to get it approved, get it on the formulary.

By the way, you have no other place to sell drugs other than drugs approved by the Canadian Government. Remember, they have a Government-run health care system up there. My understanding is that the Canadian Government actually sets their own drug prices. I do not think they go to another country to get drug prices set and use those. I think they set their own.

Assuming they are setting their own drug prices, what they do is say to the drug company, take Pfizer: OK, you want to sell your drug here? Great. We will pay you $1 a pill.

Pfizer says: This costs us $1 billion to research. It is a great drug. It solves all sorts of problems. We sell it in America for $10 because of the enormous cost of the research and testing to make sure it is safe and efficacious, and it cost us a lot of money, and we only have a short patent by which to recoup the investment dollars. We have a lot of drugs we tested along the way to find a cure for this problem, and we have to recoup those costs; otherwise, we cannot stay in business, we cannot continue to research. The Canadian Government says: That is nice; a dollar.

Pfizer says: No, we can't sell it for a dollar.

The Canadian Government says: Fine, you can't sell your drug here.

So Pfizer loses out on a market of 16 million people—I do not know how many people are in Canada—16 million people, something like that.

Pfizer says: No, we won't sell.

Or what they say is: You know what. It only costs us 50 cents to make this pill. Yes, we are not going to make any money on it, but this is a drug that is an important drug so we will make it available in Canada for a dollar.

The other alternative is they just say, no, we are not going to sell it in Canada. Under Canadian law, the Canadian Government has the right to steal Pfizer's patent, issue that patent, that formulary or formula, whatever the drug is, to a generic drug manufacturer in Canada for them to produce at the dollar price that Canada is willing to pay for it. So they can steal a patent that a company in this country spent millions of dollars, potentially a billion dollars, to come up with and set a price in Canada at the level they so choose.

The Senator from Arkansas wants to condone that behavior and say we have to charge the same price in this country.

I cannot imagine anything that would be more damaging to an industry that does more than any industry in America to solve our health problems. They spend more on research and development than any group of companies that exist, and they bring through drug after drug and therapy after therapy to extend lives, to increase the quality of life, and to cure diseases.

So the reward in the Senate is that we are going to have a foreign government set prices for an industry that

does not exist in Canada but it does exist in the United States. The majority of the new drugs in the world are researched and developed in the United States.

Yes, we do pay more for drugs in this country. I will concede that to the Senator from Arkansas. We pay more for drugs here, and the reason we pay more for drugs here is that we do not regulate prices, as most other countries around the world do.

I think the Senator from Arkansas is on to something. We need to do something about those prices around the world, but it is not to adopt them in this country; it is to get the trade administrator to start putting these issues on the table when it comes to negotiating free trade deals. They have to put on the table the pirating of our patents, with our free trade partners such as Canada and Mexico. They have to put on the table the prices they pay for drugs that are researched in this country that our people in this country subsidize. Yes, we do.

In fact, we subsidize the world's research in pharmaceuticals, admitted.

So the Senator from Arkansas says we are going to stop doing that. We are going to do what Canada does, which is not subsidize one nickel of the cost of researching these new drugs—what Germany does, what England does, what most of the developed world does. Yes, they piggyback on America, and so the Senator from Arkansas is saying let's just piggyback on Canada.

Well, what are the consequences? I do not think it takes an expert in pharmaceuticals to figure out exactly what happens. We will squeeze the research dollars out of the drugmaking industry because we will be reimbursing them based on their cost of manufacturing. So the dollars for research to attract investment dollars to spend on research and development for that next generation of drugs will be gone.

Maybe that is a good idea. Maybe it is more important to have people get their drugs inexpensively today than to find that cure for cancer, diabetes, or Parkinson's, or develop a new drug to ease symptoms of HIV. Maybe it is more important for someone to have their drugs a little cheaper today. But there are millions of Americans, and there are even more millions of people around the world, waiting for that little pill that is yet to be discovered that will extend their life so they can see their daughter or grandchild being born, waiting for someone to cure that disease they are saddled with today, to give them just a few more months or a few more years, and we will say to them, anyone who votes for this amendment, when that person walks in their office and says, I am here for NIH research dollars for diabetes, or, I am here for NIH research dollars for AIDS, Parkinson's, cancer, or heart disease, I want that Senator to say to them, I voted for this amendment and, yes, we are going to have lots of research dollars, but no one is going to take that research and do much with it because we have just squeezed every dollar we can for research and development out of the pharmaceutical industry, which would take that research and do something with it to put it to commercial practice and make that drug available.

We will say to them that even though we are passing a prescription drug benefit that is going to extend pharmaceutical benefits to make drugs less expensive, that was not good enough. No, it was not good enough to cover people's drug benefits. We have to take a bite out of the hide of those nasty pharmaceutical companies that get beaten up with frequency, I understand. They get beaten up a lot, until they are needed, until they extend your wife's life or they save your child's life; then the rhetoric tones down quite a bit.

We are shooting with real bullets. This is a Medicare pharmaceutical package that will pass and turn into law, and anybody who thinks this is a free vote, that we can go back home and campaign and say, gee, I am going to get you cheap drugs, understand what this vote means. When that 7-year-old diabetic walks in your office, understand what you have done. It is as real as denying them the cure that is sure to come.

I know this is not a popular issue, to stand up for pharmaceutical companies. Maybe we should do to them what we have done to a lot of industries that have been successful in America: Beat them up, tax them, take their profits away, until they become dependent upon us, and then we will give them loan guarantees and bail them out. Then it will be a really popular thing because they will be losing money and we will have to help them. I think that is a very bad approach.

The right approach is to provide coverage for those who are in need of insurance to help them with their prescription drug bills while at the same time allowing one of the most vibrant industries we have in this country to survive and thrive. That is the balanced approach. It is not attacking the very organizations, the companies, that are providing lifesaving drugs for millions of Americans and millions around the world.

Mr. PRYOR. Will the Senator yield for a question?

Mr. SANTORUM. I am happy to yield for a question.

Mr. PRYOR. Mr. President, I have a lot of respect for my colleague from Pennsylvania, but I would like to ask if he is familiar with this statement by Gerald J. Mossinghoff, president of Pharmaceutical Manufacturers Association. He says:

> Canada, in a move away from the system that hindered innovation, improved the patent law for medicines in 1988. Two weeks ago, it further strengthened the law by eliminating compulsory licenses for drugs approved after December 20, 1991. Drug research in Canada has increased sharply since 1988.

This is his testimony to Congress dated February 22, 1993.

What I ask the Senator is, in view of this statement, is he still maintaining that Canada can steal drug companies' patents?

Mr. SANTORUM. Yes, I do. I say that because there has been a lot of work that has been done since then. According to many legal scholars I have talked with, they still believe Canada has that ability to continue to steal licenses and give those patents away to drug companies in Canada. I will be happy to provide that documentation, but I do not have it with me. I had it last week, but the issue did not come up. I will be happy to share that.

Mr. PRYOR. If the Senator will yield for another question, Canada does take the position, as any nation would, that under its national sovereignty, it can in extreme situations take over a patent. I am sure the United States has the same provision in its law. I have not looked at the law books recently, but I know after September 11 and the anthrax scare, Canada did make the statement that it reserved the right to produce its own vaccines using existing patents.

I am guessing without knowing all the details of your statement, the policy and their intentions—by the way they did not do this—I am guessing they would have paid the pharmaceutical industry something based on manufacturing its patent, but they were doing it in their own national interest to protect their citizens.

So my question is, you pretty much imply that they routinely have the ability to steal patents; they routinely threaten that, but as best we know there has only been one example, extreme example after September 11, where they talk about the possibility of doing this.

Mr. SANTORUM. What I said in several speeches is as follows: Where there is competition, there are like classes of drugs. They use the exclusion, they use a formulary to exclude or drive down prices. If you have 10 arthritis drugs, they pick two or three, which is what a formulary is all about, and they will pick those based on the cheapest price available and patent medicines. And they will exclude others so they do not have access to the market.

I have never said in those cases the Canadian Government would use their authority to steal a patent. In fact, I have been very clear. I have said in the cases they would use it is where this is a unique drug. And if this is a unique drug, a breakthrough drug, or something that has no other competition, if you do not go along—we used the example of, I think, Cipro they were using as an example that is relevant to the case I made in the past—where there is a drug that does not have competition, that is, in fact, what they do. Leverage. In the other cases where there is competition, they have other leverage and they will not use the licensing of a patent or the stealing of a patent as a recourse.

There are two different competitive or anticompetitive maneuvers by the

Government of Canada: One having to do with drugs of which there are a variety in that class and a separate, the patent issue having to do where there is a drug with no real competitor.

This is the case I have made repeatedly, not just last week but in years past. If I was not clear on that today, I may not have been in my explanation. I apologize but that is what I have said.

Mr. PRYOR. Mr. President, I ask one additional question. A few moments ago—I know the Senator was being facetious—you talked about the nasty pharmaceutical companies and how easy it is for some to come in and impugn them and pick on them and try to punish them in some way. I don't know if you heard my comments earlier in the day, but I talked about how proud I was of a lot of what the pharmaceutical industry does in this country and around the world. In fact, I compared the advances in medicine to the advances in aeronautics in the last 100 years. The advances in medicine have been more remarkable than those of aeronautics. It is critical to have a robust industry on the cutting edge but at the same time two of the reasons the pharmaceuticals like to do their research in this country is because of the large amounts of money we fund to NIH. They do very valuable research that the pharmaceutical companies operating here can take advantage of, and we give them a very hefty research and development tax credit. I am for that credit. I am a cosponsor to continue that credit. I think it is critical for the industry.

I hope the Senator was not implying that I am a big critic of pharmaceutical companies. Bear in mind, I don't think they always have clean hands. I have seen in my work as attorney general and reading the newspapers some business practices I wish they would change. We dealt with those at the State level when I was attorney general. The Senate is starting to deal with some of those.

Mr. SANTORUM. I was not in any way suggesting you, individually, with respect to pharmaceutical companies. I was suggesting the amendment is very damaging to that research.

The Senator mentioned we subsidized through NIH research, as we do a variety of other fields, not just pharmaceuticals, as well as providing research and development tax credit, which, of course, we do not just for pharmaceuticals but for a variety of different industries. What we also do is have the FDA process which is the most expensive and cumbersome existing in the world. It takes months, and in most cases years, longer to get a drug to market, and that cap starts from the time you file, not from the time of FDA approval. The fact we had a year or 2 or 3 or more, when drugs are available in other countries and not available here, it makes the time to recoup the investment shorter. That is one of the reasons our prices are high, because of the shorter time drug companies have as an opportunity to recoup their investment. They have a longer period of time in places such as Canada, which does not require the testing we do and the trials we do.

The other reason is we also have a very expensive litigation system in this country. Pharmaceutical companies, not surprisingly, because they deal in the area of health care, are in court a lot for adverse reactions to their pharmaceutical products. Other countries do not have nearly the lucrative civil justice system, medical liability system, that we have in this country. Therefore, the costs associated with selling pharmaceuticals in this country because of our litigation system are disproportionately higher than they are in places such as Germany, Canada, and others that do not have the same kind of rewards we see in this country for harm done to people that ingest the drugs.

It is not just what we do to subsidize. Canada would say they probably provide a percentage of money in there to help research, and I am sure the other countries would say they do the same; that they contribute a share toward research, too.

As much as we subsidize, we probably cost them when it comes to the existing structure of the FDA and the legal system in this country. I argue that, yes, we may help, but we probably give with one hand and take with the other.

The bottom line is, this amendment delegates to the country of Canada the authority to set drug prices in this country. I don't know whether the Senator from Arkansas has considered whether drugs that are not set by formulary in Canada, whether those prices would not be set in this country, or only those on the formulary are set. In the end, if this would pass, you would have a lot of drug companies probably not selling drugs in Canada because by doing that, they give up this market.

My guess is the folks who are probably against this more than any other U.S. Senator, including myself, are probably the people in Canada who, if this were to pass, we probably would not find one pharmaceutical company willing to sell the drug in Canada if they would lose their market here. That may not be your intention, but I suspect that would be the consequence because it is a pretty small market up there compared to here. It is not profitable up there compared to here. My guess is you would have the undesirable effect of affecting the health care of millions of Canadians when it comes to the ability to get new drugs; or conversely you would be requiring the Canadian Government, and maybe this would be good, to raise the reimbursements for their drugs. That may be the desirable impact. That is not something I would be willing to take a chance with, as to whether the Canadian Government would respond in a favorable fashion, at least to my understanding, to this amendment by actually increasing drug prices over there so they could keep some level of new pharmaceuticals within their country.

I understand we are not going to be voting on this immediately, this is going to be voted on tomorrow at some point. But I did want to come to the floor and just urge my colleagues, even if you are for reimportation, this is a fundamentally different thing. This is just completely changing the drug pricing structure of the United States of America and delegating it to a foreign entity. I strongly suggest if you want to do that, if you want to set drug prices, let's have an amendment to set drug prices. My goodness, let's not delegate it to the people of Canada to set our drug prices. Even if you are for reimportation, even if you are for cheaper drug prices, don't let the Canadian Government do it. Get the glory of setting it ourselves, if we want to do something.

I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

AMENDMENT NO. 933

Mr. GRASSLEY. Mr. President, I ask for the regular order with respect to the Bingaman amendment, No. 933.

The PRESIDING OFFICER. The regular order is amendment No. 933.

Mr. GRASSLEY. Mr. President, I move to table the amendment, and ask for the yeas and nays, to have the vote occur at 5:30 and that the time between now and 5:30 be evenly divided.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

Mr. GRASSLEY. I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second? There is a sufficient second.

The yeas and nays were ordered.

Mr. KENNEDY. Mr. President, could I ask, now do we have 3 minutes or so on each side?

Mr. BAUCUS. Yes, we do.

Mr. KENNEDY. Could I have one of the 3 minutes?

Mr. BAUCUS. Absolutely. How many minutes does the Senator want?

Mr. KENNEDY. Can I have a minute and a half? I see others who want to address this issue.

Mr. BAUCUS. I yield the Senator 2 minutes.

The PRESIDING OFFICER. The Senator is recognized for 2 minutes.

Mr. KENNEDY. Mr. President, I hope this amendment will not be tabled. First, I commend the chairman of the committee and the ranking minority member of the committee. They have made a major step forward in reducing what we call the asset test.

Under the assets test, any senior who managed to scrape together more than $4,000 in a savings account wouldn't qualify for the most generous benefit. Those elderly persons with a minimum amount of possessions, even if they are just above the very minimum wouldn't qualify. We are even talking about limits to the amounts that can be set

aside for a burial plot or the value of personal items like jewelry or a car.

This bill we have before us has reduced the asset test in a very significant and dramatic way for seniors who have income above 135 percent of poverty. But it still remains for those who are poorest of the poor. The Bingaman amendment costs only about $3 billion, but would substantially benefit the neediest of our seniors.

In addition, the paperwork for the assets test is demeaning and an additional burden on senior citizens. I looked over the form in Georgia, for example, and it is about 10 pages long. In another State it is 16 pages long. We are talking about a test which will effectively reduce the availability of absolutely needed prescription drugs for the seniors who are the poorest of the poor.

The bill before us has made very substantial progress in helping our neediest seniors. The Bingaman amendment would just finalize it and effectively say we are not going to use an asset test as a condition to be able to participate in the prescription drug program.

I do not see my friend and colleague, the Senator from New Mexico, here on the floor. But I want the Senator to know that it is a thoughtful amendment and it will assure that low income seniors have access to the special assistance they need without pauperizing themselves or undergoing this demeaning procedure. A senior with income below the poverty line and who didn't pass the assets test under the current bill would pay 10 percent of the cost of the drugs, whereas under the Bingaman amendment she will have to pay only 5 percent. That doesn't sound like a lot of money around here but it is a lot of money for some of the most needy senior citizens.

I commend the committee for what they have done. I hope we will continue to make progress in this area and not table the Bingaman amendment.

Mr. GRASSLEY. Before I yield 3 minutes to the Senator from Pennsylvania, I ask unanimous consent Senator MURRAY's amendment be the first in order after the vote, and that any other amendment in order be laid aside.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

Mr. GRASSLEY. I yield 3 minutes to the Senator from Pennsylvania.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SANTORUM. Mr. President, I understand the point which the Senator from New Mexico is trying to accomplish. We do this in Pennsylvania. We do not have an asset test for our PACE Program. If you asked anybody up there now, Pennsylvanians dealing with this PACE Program, with the budget shortfall, one thing they would like to have put back in the box is this asset test.

You could have, conceivably, somebody who has a $1 million house and has all their investments in a house or has other assets that are not income producing and they could qualify for a very rich drug benefit under this amendment. It really does encourage people to put their money into nonproducing assets to qualify, particularly those who are sick, to qualify for a drug benefit. I just think these asset tests are a way of recognizing that income is not the only measure of what you can afford to pay when it comes to drugs. We have to look at what people own and the assets they have.

You can have someone who has very high asset value and very low income. We run into that all the time. That is the reason we have a variety of different taxes, to make sure we get at different ways in which people accumulate wealth and hold assets or live off income.

So I just say while this is well intentioned, it opens up a Pandora's box to have people who have, frankly, lots of resources—potentially lots of resources to be able to provide for themselves and also would lead, I would argue, to unwise public policy to encourage people toward planning when they retire to put their assets in nonperforming or nonincome-producing assets at a time when they probably should do otherwise.

While it is well intentioned, it could lead to a variety of problems. It is also a very expensive amendment and opens it up to millions more people, and this is already a bill that many believe is very generous to people who have a substantial amount of money. We should not be expanding this program in the subsidies to people who have a lot of assets that may not be income producing.

I reserve the remainder of my time.

Mr. KENNEDY. Mr. President, if there is no one else on our side I would like to speak for another minute, if I could. Do we have the time?

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, the author of the amendment is not here. I think he was caught a bit off guard when it was announced the vote would be on his amendment at 5:30. I understand he is on his way over here. I think it is only fair he be allowed to speak for a couple or 3 minutes at least on his amendment.

I ask consent the vote on the Bingaman amendment not be at 5:30 but at 5:40, and the remaining 10 minutes be equally divided.

The PRESIDING OFFICER. Is there objection?

Mr. HARKIN. Reserving the right to object, might I inquire of the Chair what is the procedure after the vote?

The PRESIDING OFFICER. Under a previous order, the first amendment will be that of the Senator from Washington, Senator MURRAY.

Mr. KENNEDY. Mr. President, could I ask the floor manager, if Senator BINGAMAN is not here, could I have the remaining minute?

Mr. BAUCUS. I yield to the Senator from Massachusetts, but inform Senators when the time has expired I am going to suggest the absence of a quorum.

Mr. KENNEDY. Mr. President, we are not talking about individuals who have $1 million homesteads. We are talking about seniors who have $10,000 in income. We are talking about poorest of the poor of our senior citizens. This idea people are going to be able to circumvent it because they have $1 million and $10,000 in income is ridiculous on its face. Perhaps that individual is saving $5,000 in order to fix the roof in 2 or 3 years. They will not be eligible to be able to qualify under the program here.

This is really the poorest of the poor, and we are talking about incomes of $10,000 or less. That is what this amendment is about. At least I hope it would not be tabled. And if there is some kind of condition in terms of the value of their home, as the Senator from Pennsylvania has outlined, we can work that out. But we are talking about the poorest of the poor. If that is the kind of protection the Senator from Pennsylvania is interested in, Senator BINGAMAN is interested in, we are interested in, let's work it out, but let's not table the amendment.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SANTORUM. Mr. President, do I have time remaining?

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SANTORUM. Mr. President, if the Senator wants to focus on the poorest of the poor, he should leave the assets test in place because that is exactly what it does. It says that you have low income and low assets. So we have, in fact, covered exactly what the Senator from Massachusetts is attempting to do.

What the Bingaman amendment does is leave open the possibility of the poorest of the poor not being the most heavily subsidized, that people who do have a big house, or other property, or amassed antiquities of some sort that may be very valuable—a coin collection, who knows that they would be focused in on as much as people who simply have nothing, have no place else to turn. So the assets test is very important for these scarce resources to be focused on those who need them most.

If you really do care about focusing on the poorest of the poor, and not just opening this up to people who may not need the assistance as badly, you would vote against the Bingaman amendment.

The PRESIDING OFFICER. The Chair advises the time has expired.

The Senator from Montana.

Mr. BAUCUS. Mr. President, I ask unanimous consent that Senator BINGAMAN be allowed to speak for 2 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from New Mexico is recognized for 2 minutes.

Mr. BINGAMAN. Thank you very much, Mr. President. And I thank the Senator from Montana.

First, Mr. President, I understand there is an intent to try to table this amendment at this point. Obviously, I would object to that. And I believe there are others who want to speak. I would like to try to accommodate any real concerns the majority has. So at this point, I ask unanimous consent that I be allowed to withdraw the amendment until it can be perfected in a way the majority would support.

The PRESIDING OFFICER. Is there objection?

Mr. GRASSLEY. I object.

The PRESIDING OFFICER. Objection is heard.

The Senator from Nevada.

Mr. REID. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. REID. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. Mr. President, I ask unanimous consent to speak for 30 seconds.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. REID. Mr. President, I do not know if the motion is going to be to table this. I assume so. If it is, it is our recommendation we all move to table this, and Senator BINGAMAN will just offer this again tomorrow.

Mr. BINGAMAN. Mr. President, do I still have any time?

The PRESIDING OFFICER. The time has expired.

Mr. BINGAMAN. Mr. President, I ask for 30 seconds to explain my vote.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from New Mexico.

Mr. BINGAMAN. Mr. President, I am going to go ahead and vote with the manager of the bill to table my own amendment now in order that we can bring this back here tomorrow. I will plan to reoffer the amendment, and hope that if there are real problems with it, those can be brought to my attention before we reoffer the amendment tomorrow. It is a very important issue. It is one we need to deal with in a responsible way. I urge all colleagues to go ahead and vote to table at this time.

Mr. GRASSLEY. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll to ascertain the presence of a quorum.

The legislative clerk proceeded to call the roll.

Mr. BINGAMAN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 933 WITHDRAWN

Mr. BINGAMAN. Mr. President, I renew my request that I be allowed to withdraw the amendment that I have related to the assets test at this time and reoffer it tomorrow after I have had a chance to consult with more of my colleagues.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is withdrawn.

Mr. BINGAMAN. I ask unanimous consent to add Senator DOMENICI as a cosponsor of the amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

The majority leader.

Mr. FRIST. Mr. President, for information of our colleagues, because we initially set a vote for 5:30 tonight, for clarification, we will not have any votes tonight. We will not be voting because the amendment was just withdrawn. That decision was just made in the last 15 minutes. I know a lot of people had planned the course of the day to be voting tonight. Right now, other amendments have been introduced in the last few hours, and suggestions have been made, well, let's go to those amendments. In truth, a lot of people are showing up right at 5:30. I am uncomfortable having Senators come in and all of a sudden voting on those amendments.

I think the best thing, after talking to the managers, is not to have a vote tonight at this juncture but to have people continue to offer their amendments. We will continue the debate, and we will begin the orderly voting on amendments under the direction of the two managers tomorrow.

The PRESIDING OFFICER. Who yields time? The Senator from Montana.

Mr. BAUCUS. Mr. President, it is my understanding that under the unanimous consent request, it is in order for the Senator from Washington, Mrs. MURRAY, to offer an amendment. Accordingly, I ask unanimous consent that all pending amendments be temporarily laid aside so she may offer her amendment.

The PRESIDING OFFICER. Is there objection?

Mr. HARKIN. Reserving the right to object, I did not hear the request.

Mr. BAUCUS. Mr. President, if I might repeat the request, that all pending amendments be temporarily set aside so the Senator from Washington may offer her amendment.

Mr. HARKIN. Mr. President, I have no objection. I ask unanimous consent that I be permitted to offer my amendment which will only take a few minutes after the Senator from Washington finishes her amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Washington.

AMENDMENT NO. 990

Mrs. MURRAY. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Washington [Mrs. MURRAY] proposes an amendment numbered 990.

Mrs. MURRAY. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To make improvements in the MedicareAdvantage benchmark determinations)

At the end of subtitle A of title II, add the following:

SEC. ___. IMPROVEMENTS IN MEDICAREADVANTAGE BENCHMARK DETERMINATIONS.

(a) REVISION OF NATIONAL AVERAGE USED IN CALCULATION OF BLEND.—Section 1853(c)(4)(B)(i)(II) (42 U.S.C. 1395w–23(c)(4)(B)(i)(II)), as amended by section 203, is amended by inserting ''who are enrolled in a MedicareAdvantage plan'' after ''the average number of medicare beneficiaries''.

(b) CHANGE IN BUDGET NEUTRALITY.—Section 1853(c) (42 U.S.C. 1395w–23(c)), as amended by section 203, is amended—

(1) in paragraph (1)(A)—

(A) in clause (ii), by striking the comma at the end and inserting a period; and

(B) by striking the flush matter following clause (ii); and

(2) by striking paragraph (5).

(c) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES IN CALCULATION OF MEDICAREADVANTAGE PAYMENT RATES.—

(1) FOR PURPOSES OF CALCULATING MEDICARE+CHOICE PAYMENT RATES.—Section 1853(c)(3) (42 U.S.C. 1395w–23(c)(3)), as amended by section 203, is amended—

(A) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (E)''; and

(B) by adding at the end the following new subparagraph:

''(E) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 2006), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.''.

(2) FOR PURPOSES OF CALCULATING LOCAL FEE-FOR-SERVICE RATES.—Section 1853(d)(5) (42 U.S.C. 1395w–23(d)(5)), as amended by section 203, is amended—

(A) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (C)''; and

(B) by adding at the end the following new subparagraph:

''(C) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the local fee-for-service rate under subparagraph (A) for a year (beginning with 2006), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved

under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on and after January 1, 2006.

Mrs. MURRAY. Mr. President, Congress is about to update Medicare to finally help seniors with prescription drugs, and while I have some real concerns about the way this bill would provide drug coverage, I am convinced that after 5 years of stalemate, it is time to pass a drug benefit now to begin to get seniors the help they need.

Mr. President, I have been working to improve this bill by providing additional funding in the Budget Committee, by supporting various amendments, and by offering my own amendment.

I want to make sure that the drug benefit we create will help as many seniors as possible. Before we add a new benefit to Medicare, we have to remember that there's a serious problem with Medicare today that penalizes seniors based on where they live. The problem is in the payment formula that Medicare uses, and it hurts many seniors.

Today under Medicare, some seniors can get fewer services—and pay higher premiums—just based on where they live. Every senior pays the same amount into Medicare, but some seniors get much fewer benefits based on geography. That's not fair to seniors in my State and in other States.

For the past few years, I've been working to fix that problem. Last year, I introduced the MediFair Act to bring all States up to the national average in Medicare payments. We are still working to fix this disparity in Medicare today. The problem is that this new drug benefit would follow that same old, unfair formula. It means that seniors in States such as Washington will have few choices and pay higher premiums.

That's why I'm offering my amendment today—to give seniors more choices and lower premiums as they get healthcare and prescription drugs.

As we improve Medicare, we shouldn't build on the unfair polices of the past. While I am still working to fix the underlying formula that's hurting seniors in my State, we can at least avoid perpetuating an unfair system in this new benefit. I am proud to report that we have made some progress recently to fix the regional disparity that penalizes many Medicare patients. I am pleased to have joined with Senators GRASSLEY and BAUCUS in closing the rural versus urban gap in reimbursements.

And, earlier this year, the Budget Committee unanimously adopted the Feingold-Murray-Johnson amendment, which modified the Medicare reserve fund to allow legislation to promote geographic equity in Medicare payments.

Back in 1997, when we expanded Medicare+Choice, we took some steps to make it fairer. Since the Medicare+Choice rate was based on the fee-for-service rate, it was important to provide some guaranteed level for states with low reimbursements. We did two things. First, we set a minimum payment—known as a floor—so that no county would fall below a certain level. Second, we tweaked the funding formula to provide greater equity across the country for everyone on Medicare. That approach is known as a ''blend'' because it takes the regional formula and blends it with the national average. Those were both good steps. There was only one problem: Congress never provided the funding to revise the formula. So we put a fix in the law, but we never funded it. We have not been able to fund it until now because it has to be budget neutral.

Today, my amendment would finally fund that technical correction and give seniors better access to care. Specifically, my amendment fully funds the Medicare+Choice blend formula starting in 2006 for determining the Medicare Advantage benchmark. If we don't fix this problem, we will deny many seniors access to coordinated care.

PPO's and HMO's will only go into those regions already at the higher end of per beneficiary reimbursement. We should—at the very least—try to create a level playing field for all regions of the country. It is unfair to talk about competition when some regions will receive hundreds of dollars more per beneficiary than others.

During this debate, I have listened to my colleagues talk about the benefits of PPO's and HMO's as part of their new Medicare Advantage. Senator FRIST has spoken several times on the benefit of a coordinated care approach for improving disease management and keeping seniors healthier longer. While I still have some concerns about how these new plans will operate, I want to be sure that seniors in Washington State and other States with low Medicare reimbursement can take advantage of Medicare Advantage. I also want to point out that is not about increasing payments to insurance plans. It's about ensuring that seniors in all regions of the country have access to competitive Medicare Advantage plans.

My amendment is similar to language adopted in the House Ways & Means Committee mark. However, I do not fully fund the blend in my amendment until 2006. The House proposes the change starting in 2004. I also point out that my amendment doesn't force plans in any State or region to do anything. If they want to base Medicare Advantage on either the current fee-for-service rate—or the Medicare +Choice rate—they are free to do so. My amendment gives plans a third option that could be more fair and could help more seniors.

Finally—in an effort to truly measure the cost of providing care to all seniors—my amendment directs the Department of Health and Human Services to determine the costs of care provided to Medicare beneficiaries at DoD or VA facilities. Since Medicare assumes the reimbursement, these beneficiaries should be counted in the equation.

Failing to account for the cost of this care has resulted in lower fee for service per beneficiary costs. Those lower fee-for-service rates means significant inequities in Medicare reimbursement. We should correct this existing flaw before we build a new drug benefit around it.

I have been trying to get HHS to take this step since 1997 and supported language in BIP A2000 directing HHS to report to Congress on recommendations for correcting this inequity. Unfortunately, HHS remains unwilling or unable to properly determine the actual cost of care in any given region or State.

SELF-INJECTABLES

Mr. President, I want to take just a moment to update my colleagues on another amendment that I will be offering soon with Senator CONRAD and Senator SMITH. It relates to a new, exciting group of drugs known as self-injected biologics, and it's a chance to give Medicare patients access to the benefits these new drugs offer. Senator CONRAD offered a similar amendment during the Senate Finance Committee mark up and received a commitment from the Chair to work with us on this effort. As a result of this commitment, Senator CONRAD withdrew the amendment. We have been working with CBO and Senator BAUCUS' staff to address any concerns.

Currently, Medicare will only cover biologics if they are administered in a physician's office or clinical setting. That means patients must travel to the physician's office to receive treatment. That's not easy for many patients who have Rheumatoid Arthritis or MS—two diseases that can severely limit a person's mobility.

Fortunately, there are versions of these drugs that a patient can take in their own home. It's a great innovation that will improve a patient's access. Unfortunately, Medicare won't cover biologics that are administered in the home. That just doesn't make sense. I have been working to correct this inequity for the past two Congresses. The Murray-Conrad-Smith amendment would provide two years of coverage, under Part B, for those self injected biologics that replace treatments currently available only in a physician's office. We allow for two-year coverage to bridge the gap to implementation of a Medicare prescription drug benefit.

We have received a CBO score for the two years and believe that we can find room in 2004 and 2005 to provide this important coverage for MS and RA patients. This legislation is strongly endorsed by the Arthritis Foundation and will provide additional coverage to all four MS self-injected or self-administered treatments. For MS, only one

treatment is covered under Medicare, provided in a physician's office.

I am hopeful that the managers of this legislation will be able to accept our amendment and end this discriminatory practice in Medicare.

Let me close by returning to the amendment currently before the Senate. For those Senators concerned about the inequities in the current Medicare reimbursement rates, I urge you to support this amendment. Fully funding the blend—as a third option in determining the Medicare Advantage benchmark—will provide greater equity and ensure that all seniors in all regions have access to a competitive, managed and coordinated care approach. Let's finally stop an unfair system and give seniors the access they deserve. It's the right thing to do, and I urge its immediate passage.

I yield the floor.

The PRESIDING OFFICER. Who seeks time?

The Senator from Iowa.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that we set aside the pending amendment so Senator HARKIN can offer his amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 991

(Purpose: To establish a demonstration project under the Medicaid program to encourage the provision of community-based services to individuals with disabilities)

Mr. HARKIN. Mr. President, I have an amendment at the desk and ask for its consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Iowa [Mr. HARKIN] proposes an amendment numbered 991.

Mr. HARKIN. Mr. President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER (Mr. CHAMBLISS). Without objection, it is so ordered.

(The amendment is printed in the RECORD under ''Text of Amendments.'')

Mr. HARKIN. Mr. President, I am proposing this amendment, which would enact into law the ''Money Follows the Person'' rebalancing demonstration project. This project was part of President Bush's 2004 budget request. It is a critical component of President Bush's new freedom initiative.

This really is about freedom. It is about the freedom of people with disabilities to enjoy the same opportunities for employment and community living that are available to all Americans.

A number of years ago after the passage of the Americans with Disabilities Act, a number of us began working on what we considered to be the next step in trying to provide for a more open environment for people with disabilities. And that was to get more people out of confined living—nursing homes and institutions—and put them into community-based living arrangements.

The bill we have been working on to do that is called MiCASSA, which is the shorthand for the Medicaid Community Attendant Services and Support Act. I have been working on the bill for 10 years. In fact, I note for the record that the first introduction of this bill took place in the House in 1997 and was introduced by none other than the Speaker of the House Newt Gingrich. It was first introduced in the Senate in 1999, and I was the chief sponsor of it at that time.

My amendment basically would take what the President suggested in his budget and make it operable. My amendment would take the President's proposal for giving grants to States to transition individuals into community-based living under the existing Medicaid program.

Under the President's proposal, the Centers for Medicaid and Medicare would give out to States $350 million per year for 5 years. This money would pay 100 percent of the cost for community-based services for the first year after individuals with disabilities move out of an institution or a nursing home. After that time, the Federal Government would pay its regular Medicaid rate.

This amendment and the President's proposal was for a demonstration program for 5 years. So the total cost of this will be $1.75 billion over 5 years, and it will end because then the States would go back to their normal process and procedure. The idea behind this is to give States the upfront money they needed to get people with disabilities out of nursing homes and get them into community-based living.

I believe the President proposed this initiative because he recognized that, unfortunately, under current Federal Medicaid policy, the deck is stacked in favor of living in an institution. For example, right now under Medicaid, States are required to provide nursing home care, but they are not required to provide home and community-based services.

Data from 2001 indicates that 70 percent of Medicaid funds are now being spent on institutional care and only 30 percent for community-based care. That is a shameful statistic that needs to change. As the administration's documents state, this initiative would ''level the playing field.''

Some might argue this is a Medicare bill and we should not include a Medicaid initiative. However, there are other Medicaid provisions in this Medicare bill, presumably because they are important to some of our colleagues.

This amendment, I believe, is just as worthy, and I would argue more so because it helps fulfill our goals in passing the Americans with Disabilities Act 13 years ago. In fact, the 13th anniversary of the Americans with Disabilities Act is coming up on this July 26. Thirteen years ago we made specific findings about institutionalization and the continued segregation of individuals with disabilities.

I was one of the leading sponsors of the Americans with Disabilities Act, and I know firsthand the effects of segregation of people with disabilities. I told the story often about my brother Frank. When he was a young boy, he became deaf because he had spinal meningitis. He became totally deaf. They picked him up, took him away from home, and sent him halfway across the State to a segregated school for the deaf. The people referred to it as a school for the deaf and dumb. As my brother always said, I may be deaf, but I am not dumb. That is what it was like in those days. It continues on today, that people with disabilities are segregated and sent to live in institutions.

A couple of years ago, 1999, a very famous case made its way to the Supreme Court. It is referred to as the Olmstead case. The Supreme Court ruled in 1999 that confinement in an institution is discrimination. The Supreme Court stated that when you segregate someone, as was being done in Georgia—and this case just happened to originate in Georgia. I am not picking on that State, but it happens in all other States. This Olmstead case just happened to originate in Georgia. When the Supreme Court looked at the case, they said when you segregate someone, you are telling them they are ''unworthy to participate in community life.'' That is the Supreme Court decision.

That Supreme Court decision said that States must offer the least restrictive environment to people with disabilities. The problem is, 4 years later after the Supreme Court ruling, there are still countless Americans with disabilities institutionalized, needlessly institutionalized.

This amendment is a win-win program. It would not only help offer more choices to people with disabilities, it would provide the resources to States during a very difficult fiscal time. Studies have shown States that rebalance their long-term services system can realize substantial savings. The Lewin Group did a study of three States that increased their use of home and community-based waivers instead of nursing homes in the early nineties. In one year, Colorado saved $42 million, Oregon saved $49 million, and Washington saved $74.5 million.

The researchers explained these States were able to get such high cost savings by targeting people with disabilities who were very likely to go into a nursing home. In our amendment, we are targeting those who are already in an institution or nursing home. So States are already spending large sums of money on these people.

Based on data provided by the Congressional Research Service, nursing homes cost approximately $57,000 per year per person. Institutions for individuals with mental retardation cost $88,000 per person per year. Home and community-based waivers are roughly $30,000 to $50,000 cheaper per person than these institutional cases.

The problem is States cannot afford the upfront costs that are needed to move people out of institutions and into community-based living. For example, housing may need to be modified to be accessible. That costs money. An individual may need some education and services to get ready to move out of an institution, especially if they have been there a long time, say, 20 years or more. The State may need resources to develop sufficient community providers and rebalance its long-term service program.

There are a lot of upfront costs a State would have to do to get someone with a disability out of a nursing home, out of a State institution, and into a community-based living environment.

The amendment I am offering implements President Bush's own budget request for 2004. It will be an upfront investment to help these States do that transition. It is a demonstration program for 5 years to those States that need the help.

I applaud the President for proposing this program as part of his new freedom initiative because it really is about freedom: The freedom to live with family and friends, not with strangers; the freedom to take a walk in one's own neighborhood, not just on their ward; the freedom to be a person and not a patient.

No one should have to sacrifice their freedom to participate in society because they need help getting out of the house in the morning or assistance with personal care or some other basic service. Think about it. That is what happens to people with disabilities. They sacrifice their freedom to participate in society because they may need a little help in the morning, a little bit of help at night, or a little bit of attendant services.

As taxpayers, we know it is cheaper for us to provide that kind of home-based, community-based service rather than putting people in institutions. But back when we built the institutions, when we started the nursing home care for people with disabilities that is what we believed, that people ought to be segregated.

We have changed as a society, and I think we have changed for the better. It is not unusual now to see people with disabilities in all walks of life, working on the Senate floor, in our court systems, on the shop floor, running businesses, shopping in the store, eating in a restaurant, going to an amusement park. I argue what is unusual is that in the year 2003, to say we are going to take taxpayer money and we are going to institutionalize someone with a disability who does not want to be institutionalized, who would rather live in the community, who would like to go out for a walk in the daytime, who might want to go down to the corner store and purchase some things, who might want to go to a movie now and then.

Recently, I received a letter from someone who had been moved to community-based living. She said she went to a movie for the first time in 3 years. Think about that. It was the first time in 3 years because she had been in an institution and she could not go to the theater. Now she can go to the movie theater.

I hope Senators will think about this. As I said, it is in the President's budget. He has requested it. I have offset it. So I can see no reason we should not take this step to make sure people with disabilities can get back into the community where they belong and where they want to be, with their family and friends, and not shut up with strangers, with people they may not know, segregated from society.

I urge my colleagues to act now. Freedom does not need a lot of debate and discussion. The freedom for people with disabilities ought to be happening right now.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the pending amendments be temporarily laid aside so the Senator from Minnesota may offer up to three amendments in succession.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Minnesota.

AMENDMENT NO. 957

Mr. DAYTON. I thank the Senator from Montana, and I will call three amendments up at this time. The first is amendment No. 957.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Minnesota [Mr. DAYTON] proposes an amendment numbered 957.

Mr. DAYTON. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To provide that prescription drug benefits for any Member of Congress who is enrolled in a health benefits plan under chapter 89 of title 5, United States Code, may not exceed the level of prescription drug benefits passed in the 1st session of the 108th Congress, and for other purposes)

At the appropriate place insert the following:

SEC. ___. LIMITATION ON PRESCRIPTION DRUG BENEFITS OF MEMBERS OF CONGRESS.

(a) LIMITATION ON BENEFITS.—Notwithstanding any other provision of law, during calendar year 2004, the actuarial value of the prescription drug benefit of any Member of Congress enrolled in a health benefits plan under chapter 89 of title 5, United States Code, may not exceed the actuarial value of any prescription drug benefit under title XVIII of the Social Security Act passed by the 1st session of the 108th Congress and enacted in law.

(b) REGULATIONS.—The Office of Personnel Management shall promulgate regulations to carry out this section.

Mr. DAYTON. I ask unanimous consent that amendment be set aside and we proceed to the next amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 960

Mr. DAYTON. I call up amendment No. 960.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Minnesota [Mr. DAYTON] proposes an amendment numbered 960.

Mr. DAYTON. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To require a streamlining of the medicare regulations)

At the end of subtitle A of title V, add the following:

SEC. ___. STREAMLINING AND SIMPLIFICATION OF MEDICARE REGULATIONS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct an analysis of the regulations issued under title XVIII of the Social Security Act and related laws in order to determine how such regulations may be streamlined and simplified to increase the efficiency and effectiveness of the medicare program without harming beneficiaries or providers and to decrease the burdens the medicare payment systems impose on both beneficiaries and providers.

(b) REDUCTION IN REGULATIONS.—The Secretary, after completion of the analysis under subsection (a), shall direct the rewriting of the regulations described in subsection (a) in such a manner as to—

(1) reduce the number of words comprising all regulations by at least two-thirds by October 1, 2004, and

(2) ensure the simple, effective, and efficient operation of the medicare program.

(c) APPLICATION OF THE PAPERWORK REDUCTION ACT.—The Secretary shall apply the provisions of chapter 35 of title 44, United States Code (commonly known as the ''Paperwork Reduction Act'') to the provisions of this Act to ensure that any regulations issued to implement this Act are written in plain language, are streamlined, promote the maximum efficiency and effectiveness of the medicare and medicaid programs without harming beneficiaries or providers, and minimize the burdens the payment systems affected by this Act impose on both beneficiaries and providers.

Mr. DAYTON. Mr. President, I ask unanimous consent that the amendment be set aside in order to bring up the third amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 977

Mr. DAYTON. Mr. President, I call up amendment No. 977.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Minnesota [Mr. DAYTON] proposes an amendment numbered 977.

Mr. DAYTON. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To require that benefits be made available under part D on January 1, 2004)

On page 134, strike line 9 and insert the following:

under paragraph (1).

''(d) IMPLEMENTATION OF PART D.—Notwithstanding section 1860D–1(a)(4) or any other provision of this part or part C, the Secretary shall implement, and make benefits available under, this part on January 1, 2004. The Secretary shall carry out this part until the Administrator is appointed and able to carry out this part. The Secretary shall not implement sections 1807 and 1807A.

Mr. DAYTON. I thank my colleagues for the opportunity to discuss these three amendments this evening. They will be voted on later this week, and we will be calling them up for that purpose at that time.

During my campaign for the Senate in 2000, I promised a good prescription drug coverage program for senior citizens would be one of my very first priorities. In December of 2000, after my election but just before I took office, I went up to Duluth, MN, up in the northeastern part of our State, and met with a group of senior citizens. At the end of the meeting, an elderly woman, who was about half my size and twice my age, stood up and said: Mr. DAYTON, if you do not keep your promises, I am going to take you out behind the woodshed for an old-fashioned thrashing.

It has been then with some trepidation that I have visited Duluth in the months that followed, and it is not just Duluth. Everywhere in Minnesota our elderly citizens, and actually all of our other Medicare beneficiaries who stand to benefit from this legislation, have been waiting. They have been waiting patiently and they have been waiting impatiently for the Senate, the House, and the White House to reach an agreement on a bill, pass it, and then have the President sign it into law.

During the last several years, our seniors have watched the Senate pass a bill but not the House; the House act but not the Senate; both bodies fail to pass anything; both the House and the Senate pass a bill yet be unable to agree on one and nothing passed. Meanwhile, every year that Congress and the President did nothing, our senior citizens paid the price, and then they paid another price and then another.

Prescription drug prices have risen higher and higher in this country while nothing was being done to help. The financial burdens then fell harder on people with limited and fixed incomes. People who worked hard all of their lives, saved up a bit, retired, and did not have many other earning opportunities, were literally destroyed by the rapid escalation of prescription drug medicine, medicines they cannot afford not to have, medicines they cannot afford to have.

People's peace of mind was shattered. Hopes and plans had to be abandoned, ones that had been months and years in the making. Even modest comforts and simple enjoyments had to be sacrificed to pay this ravaging beast of the pharmaceutical industry that wanted more profits out of pockets, out of the sweat and blood of senior citizens and other Americans.

The financial security and the protections from destitution and despair, which Social Security and Medicare have provided our elderly for several decades and which was one of the great accomplishments of this society, was being rapidly eradicated by drug companies' greed and Congress's and the administration's inaction.

I thought on the day when we finally acted and passed a prescription drug coverage bill for senior citizens and other beneficiaries it would be cause for real celebration and satisfaction, and I could go back to Duluth. Well, it appears that this Friday may very well be that day where we will pass in the Senate prescription drug legislation, but the way it looks now I will not be celebrating the passage of the bill that is before us right now.

It is usually true that something is better than nothing, and the bill that is before us now is barely enough of something to be better than nothing. I will probably vote for it for that reason, but I will not be celebrating because there is not enough in this bill to be worthy of celebration. For starters, it does not even begin until January 1 of the year 2006. It is unbelievable there would be a 2½ year delay from the time this bill is signed into law before it is operational.

To let that stand is a violation of the Constitution which prohibits cruel and unusual punishment for American citizens. It is cruel and unusual punishment for the senior citizens of Minnesota and their counterparts of this country who have waited this long, year after year, waiting for this legislation, bills mounting. Finally something is passed and they are told they have to wait another 2½ years for the Federal Government and the insurance industry to set up this program. Shame on us if we do not move the development of this program from the sleepwalking mode into overdrive.

Proponents of this bill say the approach using subsidized insurance plans to provide this coverage is one of the advantages—they have postulated in the Senate and committee—because it is more efficient. The insurance companies are in the business of designing and selling insurance policies. How could they need 2½ years to develop this? If they do, it seems to me that is a very compelling reason to look for a different delivery system. Some believe that would be good for other reasons, as well.

My first amendment is named the bureaucracy booster to require whatever program we pass and whatever the President signs into law to be fully operational by January 1 of 2004, 2 years earlier than the President's schedule calls for. It would be 6 months after we pass our bill later this week. It took 6 months for our armed services to assemble their forces and prepare for the war against Iraq. They were ready to go when General Franks gave his order. If this country can get ready to win a war in 6 months—and actually the war against the Taliban in Afghanistan was assembled in about 6 weeks—it certainly can start to save our senior citizens in that same amount of time.

I am also troubled by the quality of the program which will hopefully be available to everyone on Medicare, if my amendment passes, next January 1. The coverage in the bill before the Senate is not very good. I don't fault the leaders of this bill who took it through the committee process. It was a very difficult task, with Members from all over the country. They were constrained by the budget this body passed earlier this year. You can slice and dice the programs and the delivery and the structuring but the bottom line is you will get what you pay for. Maybe it is better one way or the other but the bottom line is you get what you pay for. The Finance Committee had $400 billion over 10 years and they did the best they could, but the fact is that is not enough to provide the kind of coverage the senior citizens of this country have a right to expect. It provides only half the coverage we Members of the Senate and our colleagues in the House get through the Federal employees plan.

The bill before the Senate requires a $35 a month premium and a $275 deductible, so an enrollee pays $695 each year before receiving a single dollar of assistance. From that point, for all of his or her nonreimbursement prescription drugs above the $275 deductible, up to $4,500 in 1 year, the program would pay half. At that point, incredibly, the program pays nothing then for drug costs that exceed $4,500 for one person in one year, all the way up to $5,800. I understand that was done for the purpose of fitting within this budget cap. But it seems unfair to have a 50 percent program up to one point, then have the program disappear entirely for $1,300 of expenditures, but come back after $5,800, for the balance of the year, when the program pays 90 percent. The next year it starts all over again. For the first $5,800 in annual prescription drug costs out-of-pocket payments, nonreimbursed, a senior citizen of Minnesota or America has to pay $3,688 plus they have to pay $4,200 in monthly premiums. So the total payment for the senior citizen is $4,108 and the program will pay $2,012. The senior pays almost twice as much as the program assistance. So hundreds and thousands of dollars of expenses will be paid by a very limited and fixed-income senior citizen.

It is not a good deal. It is not what we ought to be providing for our seniors. It is not as generous as the alternative bill which our colleague, the Senator from Illinois, Senator DURBIN, has offered as an alternative amendment which I am proud to work on and cosponsor. That is the kind of program I would want my mother or father to be on. It is as good a program as members of the Senate have. It would have no deductible and pay for 70 percent of the costs from the very first $1 owed up

until $5,000 and 90 percent above that. That is a much better administrative feature.

What the pharmaceutical industry wants to the death to oppose is the Federal Government CMS, the Medicare administrators getting involved in negotiating down the prices. They have free and clear now, unlike virtually any other country in the world, ability to just raise prices for prescription drugs and raise them and raise them. They are making huge profits. Most of their worldwide profits are made in the United States of America not only with our seniors but all citizens because this body and the House and White House will not stand up and do something about it. Senator DURBIN's amendment would do something. I expect the pharmaceutical industry to oppose it to the death.

I have a second amendment which I call the taste of our own medicine amendment which says if the program we pass for Medicare beneficiaries is less advantageous than the one we receive under the Federal employees health plan, the coverage for all Members of Congress, the Senate and the House, will be reduced to the same level as the coverage provided for senior citizens and others under Medicare. If it is good enough for the seniors of America, it is as good as we should do for ourselves.

My third amendment is what I call my bureaucracy buster. Earlier I had bureaucracy booster to get the program operating early. This applies to all of Medicare. It would apply, I am told by the CEO of Mayo Clinic, to 130,000 pages of rules and regulations that make up the governance of Medicare. I was going to bring 130,000 pages over here as a graphic illustration, but it is a violation of Senate rules for decency and decorum. If anyone ever saw 130,000 pages piled up, they would agree. It is bigger than all the Harry Potter books, a lot bigger than anyone involved in Medicare had a chance to look at either to apply to their hospital or clinic or to enforce, and it is one piece of this epidemic of verbiage, duplicative regulation, multiple reporting requirements we have placed on doctors, hospitals, administrators, special education teachers, school superintendents, small business, large business, this plague of ever more and more and more regulations, more complicated, more lengthy, more time consuming. We are burying our society, burying our economy, burying our delivery systems to other people and we have to start turning that around.

This amendment requires the Secretary of Health and Human Services to come back to Congress by October 1 of 2004 with a revision to the Medicare regulations and rules that amounts to two-thirds of all the words that are now being used for those purposes. It would be a two-thirds reduction in the amount of regulation and reporting. That means we have to squeeze everything down into 45,000 pages. It will just have to be done.

If my colleagues will join me in agreeing to this amendment, once it has proven to be a viable idea, it is something I would like to apply to other regulatory and reporting mechanisms in the Federal Government as well.

I yield the floor.

Mr. BAUCUS. Mr. President, I ask unanimous consent the pending amendments be temporarily set aside.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

AMENDMENT NO. 992

Mr. BAUCUS. Mr. President, on behalf of Senator STABENOW, I send an amendment to the desk regarding State rebate agreements.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS], for Ms. STABENOW, for herself and Ms. SNOWE, proposes an amendment numbered 992.

Mr. BAUCUS. I ask unanimous consent the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To clarify that the medicaid statute does not prohibit a State from entering into drug rebate agreements in order to make outpatient prescription drugs accessible and affordable for residents of the State who are not otherwise eligible for medical assistance under the medicaid program)

On page 158, between lines 4 and 5, insert the following:

(f) CLARIFICATION OF STATE AUTHORITY RELATING TO MEDICAID DRUG REBATE AGREEMENTS.—Section 1927 (42 U.S.C. 1396r–8) is amended by adding at the end the following:

''(l) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as prohibiting a State from—

''(1) directly entering into rebate agreements (on the State's own initiative or under a section 1115 waiver approved by the Secretary before, on, or after the date of enactment of this subsection) that are similar to a rebate agreement described in subsection (b) with a manufacturer for purposes of ensuring the affordability of outpatient prescription drugs in order to provide access to such drugs by residents of a State who are not otherwise eligible for medical assistance under this title; or

''(2) making prior authorization (that satisfies the requirements of subsection (d) and that does not violate any requirements of this title that are designed to ensure access to medically necessary prescribed drugs for individuals enrolled in the State program under this title) a condition of not participating in such a similar rebate agreement.''.

AMENDMENT NO. 993

Mr. BAUCUS. Mr. President, I ask unanimous consent all pending amendments be temporarily set aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BAUCUS. On behalf of Senator DORGAN, I offer an amendment with respect to coverage of cardiovascular screening tests. I send that to the desk.

The PRESIDING OFFICER. The clerk will report the amendment.

The assistant legislative clerk read as follows:

The Senator from Montana [Mr. BAUCUS], for Mr. DORGAN, proposes an amendment numbered 993.

Mr. BAUCUS. I ask unanimous consent the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To amend title XVIII of the Social Security Act to provide for coverage of cardiovascular screening tests under the medicare program)

At the appropriate place in title IV, insert the following:

SEC. ___. COVERAGE OF CARDIOVASCULAR SCREENING TESTS.

(a) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(1) in subparagraph (U), by striking ''and'' at the end;

(2) in subparagraph (V)(iii), by inserting ''and'' at the end; and

(3) by adding at the end the following new subparagraph:

''(W) cardiovascular screening tests (as defined in subsection (ww)(1));''.

(b) SERVICES DESCRIBED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Cardiovascular Screening Tests

''(ww)(1) The term 'cardiovascular screening tests' means the following diagnostic tests for the early detection of cardiovascular disease:

''(A) Tests for the determination of cholesterol levels.

''(B) Tests for the determination of lipid levels of the blood.

''(C) Such other tests for cardiovascular disease as the Secretary may approve.

''(2)(A) Subject to subparagraph (B), the Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency and type of cardiovascular screening tests.

''(B) With respect to the frequency of cardiovascular screening tests approved by the Secretary under subparagraph (A), in no case may the frequency of such tests be more often than once every 2 years.''.

(c) FREQUENCY.—Section 1862(a)(1) of the Social Security Act (42 U.S.C. 1395y(a)(1)) is amended—

(1) by striking ''and'' at the end of subparagraph (H);

(2) by striking the semicolon at the end of subparagraph (I) and inserting '', and''; and

(3) by adding at the end the following new subparagraph:

''(J) in the case of a cardiovascular screening test (as defined in section 1861(ww)(1)), which is performed more frequently than is covered under section 1861(ww)(2).''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to tests furnished on or after January 1, 2004.

Mr. BAUCUS. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. GRASSLEY. Mr. President, I ask unanimous consent the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Iowa is recognized.

AMENDMENT NO. 974

Mr. GRASSLEY. I am going to call up my amendment numbered 974, which I filed on Friday. I am pleased to offer the Drug Competition Act of 2003.

The PRESIDING OFFICER. The clerk will report the amendment.

The assistant legislative clerk read as follows:

The Senator from Iowa [Mr. GRASSLEY], for himself, Mr. LEAHY, Ms. CANTWELL, Mr. DURBIN, and Mr. KOHL, proposes an amendment numbered 974.

The amendment follows:

(Purpose: To enhance competition for prescription drugs by increasing the ability of the Department of Justice and Federal Trade Commission to enforce existing antitrust laws regarding brand name drugs and generic drugs)

At the appropriate place, insert the following:

TITLE ____—DRUG COMPETITION ACT OF 2003

SEC. ___01. SHORT TITLE.

This title may be cited as the ''Drug Competition Act of 2003''.

SEC. ___02. FINDINGS.

Congress finds that—

(1) prescription drug prices are increasing at an alarming rate and are a major worry of many senior citizens and American families;

(2) there is a potential for companies with patent rights regarding brand name drugs and companies which could manufacture generic versions of such drugs to enter into financial deals that could tend to restrain trade and greatly reduce competition and increase prescription drug expenditures for American citizens; and

(3) enhancing competition among these companies can significantly reduce prescription drug expenditures for Americans.

SEC. ___03. PURPOSES.

The purposes of this title are—

(1) to provide timely notice to the Department of Justice and the Federal Trade Commission regarding agreements between companies with patent rights regarding brand name drugs and companies which could manufacture generic versions of such drugs; and

(2) by providing timely notice, to enhance the effectiveness and efficiency of the enforcement of the antitrust and competition laws of the United States.

SEC. ___04. DEFINITIONS.

In this title:

(1) ANDA.—The term ''ANDA'' means an Abbreviated New Drug Application, as defined under section 201(aa) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(aa)).

(2) ASSISTANT ATTORNEY GENERAL.—The term ''Assistant Attorney General'' means the Assistant Attorney General in charge of the Antitrust Division of the Department of Justice.

(3) BRAND NAME DRUG.—The term ''brand name drug'' means a drug approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(c)).

(4) BRAND NAME DRUG COMPANY.—The term ''brand name drug company'' means the party that received Food and Drug Administration approval to market a brand name drug pursuant to an NDA, where that drug is the subject of an ANDA, or a party owning or controlling enforcement of any patent listed in the Approved Drug Products With Therapeutic Equivalence Evaluations of the Food and Drug Administration for that drug, under section 505(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)).

(5) COMMISSION.—The term ''Commission'' means the Federal Trade Commission.

(6) GENERIC DRUG.—The term ''generic drug'' means a product that the Food and Drug Administration has approved under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)).

(7) GENERIC DRUG APPLICANT.—The term ''generic drug applicant'' means a person who has filed or received approval for an ANDA under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)).

(8) NDA.—The term ''NDA'' means a New Drug Application, as defined under section 505(b) et seq. of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b) et seq.)

SEC. ___05. NOTIFICATION OF AGREEMENTS.

(a) IN GENERAL.—

(1) REQUIREMENT.—A generic drug applicant that has submitted an ANDA containing a certification under section 505(j)(2)(vii)(IV) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(2)(vii)(IV)) and a brand name drug company that enter into an agreement described in paragraph (2), prior to the generic drug that is the subject of the application entering the market, shall each file the agreement as required by subsection (b).

(2) DEFINITION.—An agreement described in this paragraph is an agreement regarding—

(A) the manufacture, marketing or sale of the brand name drug that is the subject of the generic drug applicant's ANDA;

(B) the manufacture, marketing or sale of the generic drug that is the subject of the generic drug applicant's ANDA; or

(C) the 180-day period referred to in section 505(j)(5)(B)(iv) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(5)(B)(iv)) as it applies to such ANDA or to any other ANDA based on the same brand name drug.

(b) FILING.—

(1) AGREEMENT.—The generic drug applicant and the brand name drug company entering into an agreement described in subsection (a)(2) shall file with the Assistant Attorney General and the Commission the text of any such agreement, except that the generic drug applicant and the brand-name drug company shall not be required to file an agreement that solely concerns—

(A) purchase orders for raw material supplies;

(B) equipment and facility contracts;

(C) employment or consulting contracts; or

(D) packaging and labeling contracts.

(2) OTHER AGREEMENTS.—The generic drug applicant and the brand name drug company entering into an agreement described in subsection (a)(2) shall file with the Assistant Attorney General and the Commission the text of any other agreements not described in subsection (a)(2) between the generic drug applicant and the brand name drug company which are contingent upon, provide a contingent condition for, or are otherwise related to an agreement which must be filed under this title.

(3) DESCRIPTION.—In the event that any agreement required to be filed by paragraph (1) or (2) has not been reduced to text, both the generic drug applicant and the brand name drug company shall file written descriptions of the non-textual agreement or agreements that must be filed sufficient to reveal all of the terms of the agreement or agreements.

SEC. ___06. FILING DEADLINES.

Any filing required under section 5 shall be filed with the Assistant Attorney General and the Commission not later than 10 business days after the date the agreements are executed.

SEC. ___07. DISCLOSURE EXEMPTION.

Any information or documentary material filed with the Assistant Attorney General or the Commission pursuant to this title shall be exempt from disclosure under section 552 of title 5, and no such information or documentary material may be made public, except as may be relevant to any administrative or judicial action or proceeding. Nothing in this section is intended to prevent disclosure to either body of Congress or to any duly authorized committee or subcommittee of the Congress.

SEC. ___08. ENFORCEMENT.

(a) CIVIL PENALTY.—Any brand name drug company or generic drug applicant which fails to comply with any provision of this title shall be liable for a civil penalty of not more than $11,000, for each day during which such entity is in violation of this title. Such penalty may be recovered in a civil action brought by the United States, or brought by the Commission in accordance with the procedures established in section 16(a)(1) of the Federal Trade Commission Act (15 U.S.C. 56(a)).

(b) COMPLIANCE AND EQUITABLE RELIEF.—If any brand name drug company or generic drug applicant fails to comply with any provision of this title, the United States district court may order compliance, and may grant such other equitable relief as the court in its discretion determines necessary or appropriate, upon application of the Assistant Attorney General or the Commission.

SEC. ___09. RULEMAKING.

The Commission, with the concurrence of the Assistant Attorney General and by rule in accordance with section 553 of title 5 United States Code, consistent with the purposes of this title—

(1) may define the terms used in this title;

(2) may exempt classes of persons or agreements from the requirements of this title; and

(3) may prescribe such other rules as may be necessary and appropriate to carry out the purposes of this title.

SEC. ___10. SAVINGS CLAUSE.

Any action taken by the Assistant Attorney General or the Commission, or any failure of the Assistant Attorney General or the Commission to take action, under this title shall not bar any proceeding or any action with respect to any agreement between a brand name drug company and a generic drug applicant at any time under any other provision of law, nor shall any filing under this title constitute or create a presumption of any violation of any antitrust or competition laws.

SEC. ___11. EFFECTIVE DATE.

This title shall—

(1) take effect 30 days after the date of enactment of this title; and

(2) shall apply to agreements described in section ___05 that are entered into 30 days after the date of enactment of this title.

Mr. GRASSLEY. This is the Drug Competition Act of 2003. I filed it as an amendment to S. 1. I do it in a bipartisan way with Senator LEAHY and many others.

Our amendment will help Federal regulators ensure that antitrust laws are not being violated and that there is full and unfettered access to competition for prescription drugs under the law.

What I want to do is make sure American consumers—and in the case of prescription drugs for Medicare, senior citizens—are able to get the lifesaving drugs they need and to do it in a competitive manner with resulting lower prices.

Our patent laws provide drug companies with incentives to invest in the research and development of new drugs,

but the law also provides that generic drug companies have the ability to get their own drugs on the market so there can be price competition and lower prices for prescription drugs. We have a legal system in place that provides such a balance; that is, the Hatch-Waxman law. Ultimately, we want consumers and seniors to have more choices and to get drugs at lower prices.

So I was concerned when I heard reports that the Federal Trade Commission had brought enforcement actions against brand-name and generic drug manufacturers that had entered into anticompetitive agreements, resulting in the delay of the introduction of lower priced drugs. Our amendment targets this problem.

I would like to explain in a little more detail the problem. Under the Hatch-Waxman Act, manufacturers of generic drugs are encouraged to challenge weak or invalid patents on brand-name drugs so that consumers can benefit from lower generic drug prices. Current law gives temporary protection from competition to the first generic drug manufacturer that gets exclusive permission to sell a generic drug before the patent on the brand-name drug expires. This gives the generic firm, then, a 180-day head start on all other generic companies.

However, the FTC discovered that some companies were exploiting this law by entering into secret deals, which allowed the generic drugmakers to claim a 180-day grace period, and to block, then, other generic drugs from entering the market, while at the same time getting paid by the brand-name manufacturer for withholding sales of generic versions of the drug. Quite a sweet deal.

This meant, then, under this sweet deal, that consumers continued to pay high prices for drugs rather than benefiting from more competition and consequently lower prices.

The Federal Trade Commission brought antitrust law enforcement actions against the brand-name and generic drug companies that had engaged in this anticompetitive behavior. In addition, the Federal Trade Commission conducted a comprehensive review of agreements that impacted the 180-day exclusivity period. The FTC found that there are competition problems with some of these agreements that potentially delayed generic drugs entering the market—just the opposite of what the FTC wanted to happen. So the FTC made this recommendation:

Given this history, we believe that notification of such agreements to the Federal Trade Commission and the U.S. Department of Justice is warranted. We support the Drug Competition Act of 2001, introduced by Senator LEAHY, as reported by the Committee on the Judiciary.

As the Federal Trade Commission has indicated in its report, the Grassley-Leahy amendment, the Drug Competition Act of 2003, is a simple solution to the 180-day exclusivity period and the problems the FTC has identified. Our amendment would require drug companies that enter into agreements relating to the 180-day period to file documents, those very documents with the FTC and the Department of Justice. Our amendment would impose sanctions on companies that do not provide timely notification. This process would facilitate agency review of the agreements. It would do it to determine whether they have anticompetitive effects. Making sure the agreement between the generic and brand-name drug companies is in compliance with the law is good for the American consumer because it guarantees free, full, and fair competition.

Both Senator LEAHY and I worked with the Federal Trade Commission and the Department of Justice, the generic and brand-name drug companies, and other interested groups in crafting the language contained in this amendment, and I think we have a very good work product that I am offering the Senate. We tried to address everyone's concerns and we tried to limit the scope of the act. We also made every attempt to ensure that the notification requirement did not unnecessarily burden industry.

I am not aware of any opposition to this language. In fact, the Drug Competition Act, passed out of the Judiciary Committee and the full Senate last year by unanimous consent, and the Federal Trade Commission report came out in full support of the Grassley-Leahy amendment as a way to help preserve healthy and open competition in the drug markets.

The Grassley-Leahy amendment will ensure that consumers ultimately are not hurt by secret, anticompetitive contracts, so the consumer can get competition and lower drug prices almost immediately. I urge my colleagues to support the Grassley-Leahy amendment.

I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

Mr. DURBIN. Mr. President, it is my understanding a number of Senators have offered amendments. I assume they have been sending them to the desk and setting them aside. Is that correct?

That is what I would like to do before we adjourn this evening.

AMENDMENT NO. 994

Mr. President, this is an amendment I have discussed with my colleagues and have spoken about on the Senate floor a few times. It is in the nature of a substitute to the underlying bill.

Let me say, though I have had many differences with my friend from Iowa about a variety of different matters we have worked on over the years, I congratulate both him and Senator BAUCUS for their leadership. I think what they have done is bring the Senate to this moment in our history where we are seriously considering a prescription drug program that will benefit the tens of millions of seniors across America. And this conversation is long overdue.

I think what they have proposed is a worthy start for a commitment that needs to be made. I think there isn't a Senator who comes to this floor who has not been back to his or her State to hear of the tales and stories of families and the struggles they are going through in paying for prescription drugs.

I was back in my hometown of Springfield, IL, over the weekend for a wedding, and out of nowhere people started coming up to me and talking about prescription drug costs: I know you are debating this in Washington.

I think this is a timely discussion. I hope, at the end of the discussion, we will have a bill that really does achieve what we hope to achieve. I think making a national commitment to a prescription drug program under Medicare is the right thing to do, but I think we need to do it with our eyes wide open.

There are several facts we should consider. Let me give you illustrations. One of them is the cost of prescription drugs is going to continue to rise dramatically unless we address it, and address it head on. They say the cost of prescription drugs goes up 10 to 20 percent a year. You can ask any senior or family and they can tell you that story.

What troubles me about the underlying bill is it does not have competitive forces that will bring these costs down. It provides for a percentage helping hand to seniors to pay for their prescription drug bills, but that percentage becomes less and less as the overall cost of prescription drugs continues to grow out of hand. The substitute amendment which I am offering is going to address this, I hope, in a meaningful way.

Just last Friday—I guess a surprise vote to some—we decided to allow America's seniors to import drugs from Canada. Why did we do that? Because everybody knows the story: The very same American drug companies that make these products in America, when they turn to sell them in Canada, give them a deep discount. Why? Because the Canadian Government says to them: If you want to sell drugs in Canada, then you have to discount the cost to Canadian citizens.

So here we are, in our States bordering Canada, just a few miles away from pharmacies in Canada selling identical drugs to those sold in America at a fraction of the cost. Now, of course, that is a benefit to Canadian citizens. And we decided last Friday we would make certain that benefit was there for American citizens.

We can reimport drugs—in other words, made in the United States, shipped to Canada for sale. We will now, under the amendment we adopted by Senator DORGAN of North Dakota, allow Americans to repurchase the drugs from Canadian pharmacies to bring them back into the United States. Isn't that an awkward, clumsy,

and convoluted way to provide a discount to America's seniors? It certainly is. But we voted for it on a pretty substantial rollcall. I think over 60 Senators supported it because we understand for many seniors that Canadian discount makes all the difference in the world.

Unfortunately, this reimportation from Canada is temporary, and it is not a permanent part of what we are debating here. In fact, there are few, if any, elements in this underlying legislation that give seniors in America a fighting chance to get anywhere near the discounted prices being offered to families in Canada for the prescription drugs they need. In other words, we are offering a helping hand from the Government to pay for your prescription drugs, but offering no force or no element—certainly very little—within this bill to try to reduce and control prices.

You may think: Is Canada that powerful that they can dictate to the American drug companies they have to discount their prices? Well, I can tell you, the Canadian market represents about 2 percent—2 percent—of the sales by American drug companies, whereas the United States market represents 53 percent. If we, as a nation, turned to these same drug companies that have bargained with Canada and said: ''We want the same thing for Americans,'' you can bet we would achieve it. But this bill does not do that. The Grassley-Baucus bill does not do this. It does not create this force for competition and this force for bringing down costs.

Some will come to the floor and say: Durbin, this amendment is nothing short of socialism. You are trying, with a radical idea, to change the market structure in America, take away the free market competition, and dictate prices, and that is just unfair. We should not do it. And that is not American.

Well, I would ask them to place a call to the Veterans' Administration because the Veterans' Administration already does the same thing. The Veterans' Administration bargains for our veterans so the prescription drugs they receive are at a reduced cost. Why, if our Government will stand up for our veterans to get reduced costs for prescription drugs, is that any different than saying, under this bill, we should also be bargaining to make certain we can bring down prescription drug costs across the board? It will mean the program is more affordable for seniors. It will also mean the money we dedicate to the program will be with us for a while, a lot longer than as proposed under this bill.

So we do several things in this substitute amendment. I am not going to take any further time other than to just say a few words about this amendment, who supports it, and what it stands to achieve.

It is being offered on my behalf, as well as Senators CORZINE, HARKIN, BOXER, STABENOW, DAYTON, and BYRD. It has been endorsed, to this point—we think other endorsements will come—by the Alliance for Retired Americans as well as the National Committee to Preserve Social Security and Medicare.

Here is what it does. It defines the benefits in statute. The underlying bill does not. It eliminates the coverage gap. The underlying bill has a coverage gap, where, after a senior has spent a certain amount of money for prescription drugs, there is no coverage until it reaches a catastrophic level over $5,000. It eliminates the deductible of $275 proposed by this bill because we found with price competition we can bring down the overall cost. It increases cost sharing. It guarantees a stable fallback. In other words, if there is not a private prescription benefit pharmacy manager offering alternatives to seniors, we allow Medicare itself to offer a prescription drug plan. That is a fallback always available under our bill. You do not have to be eliminated from the one to offer the other. This is always a fallback. And it allows employer coverage to count toward out-of-pocket spending.

The average cost for prescription drugs for seniors in this year is expected to be approximately $2,300. Under this bill we are considering on the floor today, seniors could get back maybe one fourth of that, $600. Every dollar counts and I commend my leaders in the Finance Committee for bringing this to us, but it is $600. Under the MediSAVE plan, my substitute amendment, seniors will have no deductible, lower cost-sharing, and face no coverage gap. The average senior can save up to 50 percent of the cost of those $2,300 in drugs, almost double what is offered by the underlying bill.

There is no guaranteed benefit for seniors in the underlying bill, and premiums are left up to insurance companies to decide. Under the MediSAVE plan, which I will offer, the Medicare-delivered benefit is outlined in statute so all seniors who choose to receive their benefit through Medicare will be guaranteed the same package, the same premium, no matter where they live in America.

As I said before, we address skyrocketing drug prices whereas the underlying bill does not. Incidentally, the Veterans' Administration has saved about $943 million in the past 6 years because it has bargained with the drug companies on behalf of seniors.

We also maintain choice. I see some of my Republicans friends have sent a letter to the President saying: We have to allow for innovation. We have to allow for competition. Agreed. We say: Fine, private groups and insurance companies can offer the prescription drug benefit as an option, seniors get to choose. But they always have a Medicare fallback they can choose.

Some say: We don't want this Government agency running this. Why do we want a Government agency in charge of it? Well, because Medicare has no profit motive. Medicare has a low administrative cost. If the VA runs the program for veterans and we don't consider that socialism, what is wrong with the idea of having Medicare in here competing with these private insurance companies. Eighty-nine percent of seniors today stick with Medicare rather than going to some HMO choice plan and/or private plan under Medicare. That tells you they like Medicare better. Why should we deny them this chance under prescription drugs.

MediSAVE creates a reliable fallback that is Medicare, and I think that is good for seniors. And MediSAVE will incentivize employers to maintain benefits. This is a fear we have. We don't want to do anything that will hurt the employers currently helping retired seniors, and we want to make certain we encourage their continued participation.

Under S. 1, funds employers put toward retiree costs don't count toward the retiree's Medicare out-of-pocket cost. Under MediSAVE, they would count.

Mr. President, I know it is late. I know a number of amendments have been offered. But at this point I would like to send my amendment to the desk and ask that it be read and then held at the desk.

Mr. GRASSLEY. Mr. President, reserving the right to object, I assume he asked unanimous consent to set the amendments aside.

Mr. DURBIN. Which I will do. I will send the amendment to the desk. I don't know if it should be reported at this moment, but I ask it be set aside.

Mr. GRASSLEY. Could I say this: If you would allow me, rather than reserving the right to object, when he asks unanimous consent to set aside an amendment to offer his amendment, I am not going to object to that. But the leader has asked we have no more amendments tonight. So I would then be forced to object to any other amendments from either side that would come up.

The PRESIDING OFFICER. Does the Senator object to this amendment at this time, or does anybody else object to it?

Without objection, the clerk will report.

The assistant legislative clerk read as follows:

The Senator from Illinois [Mr. DURBIN], for himself, Mr. CORZINE, Mr. HARKIN, Mrs. BOXER, Ms. STABENOW, Mr. DAYTON, and Mr. BYRD proposes an amendment numbered 994.

The amendment is as follows:

(Purpose: To deliver a meaningful benefit and lower prescription drug prices)

Beginning on page 48, strike line 13 through page 50, line 2 and insert the following:

''(1) NO DEDUCTIBLE.—

''(A) IN GENERAL.—The coverage provides for benefits without the application of a deductible.

''(B) APPLICATION.—Notwithstanding the succeeding provisions of this part, the Administrator shall not apply section 1860D–19(a)(3)(A)(ii).

''(2) LIMITS ON COST-SHARING.—

''(A) IN GENERAL.—The coverage has cost-sharing (for costs up to the annual out-of-pocket limit under paragraph (4)) that is equal to 30 percent or that is actuarially consistent (using processes established under subsection (f)) with an average expected payment of 30 percent of such costs.

''(B) APPLICATION.—Notwithstanding the succeeding provisions of this part, the Administrator shall not apply subsection (d)(1)(C) and paragraphs (1)(D), (2)(D), and (3)(A)(iv) of section 1860D–19(a). 2

On page 50, line 15, strike ''$3,700'' and insert ''$1,500''.

On page 51, strike lines 15 through 25 and insert the following:

''(ii) such costs shall be treated as incurred without regard to whether the individual or another person, including a State program or other third-party coverage, has paid for such costs.

Beginning on page 77, strike line 10 and all that follows through page 84, line 7, and insert the following:

''(e) MEDICARE OPERATED PLAN OPTION.—

''(1) ACCESS.—The Administrator shall establish and operate a national plan to provide any eligible beneficiary enrolled under this part (and not, except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage, enrolled in a MedicareAdvantage plan) electing such plan with standard prescription drug coverage. Under such plan, the Administrator shall negotiate with pharmaceutical manufacturers with respect to the purchase price of covered drugs and shall encourage the use of more affordable therapeutic equivalents to the extent such practices do not override medical necessity as determined by the prescribing physician. To the extent practicable and consistent with the previous sentence, the Administrator shall implement strategies similar to those used by other Federal purchasers of prescription drugs, and other strategies, to reduce the purchase cost of covered drugs. Eligible beneficiaries enrolled under this part shall have the option of enrolling in such plan or in a Medicare Prescription Drug plan or a MedicareAdvantage plan available in the area in which the beneficiary resides.

''(2) MONTHLY BENEFICIARY OBLIGATION FOR ENROLLMENT.—

''(A) IN GENERAL.—In the case of an eligible beneficiary enrolled in the plan operated by the Administrator under paragraph (1), the monthly beneficiary obligation of such beneficiary for such enrollment shall be—

''(i) for months in the first year of implementation, $35; and

''(ii) for months in a subsequent year, the lesser of—

''(I) the amount determined under this paragraph for months in the previous year, increased by the annual percentage increase described in section 1860D–6(c)(5) for the year involved; or

''(II) in the case of months in years prior to 2014, the specified amount.

''(B) SPECIFIED AMOUNT.—For purposes of this paragraph, the term 'specified amount' means—

''(i) for months in the second year of implementation, $37;

''(ii) for months in the third year of implementation, $40;

''(iii) for months in the fourth year of implementation, $43;

''(iv) for months in the fifth year of implementation, $46;

''(v) for months in the sixth year of implementation, $51;

''(vi) for months in the seventh year of implementation, $54; and

''(vii) for months in the eighth year of implementation, $59.

''(3) NO AFFECT ON ACCESS REQUIREMENTS.—The plan operated by the Administrator under paragraph (1) shall be in addition to the plans required under subsection (d)(1).

''(4) REQUIREMENT TO PREVENT INCREASED COSTS.—If the Administrator determines that Federal payments made with respect to eligible beneficiaries enrolled in the plan operated by the Administrator under paragraph (1) exceed on average the Federal payments made with respect to eligible beneficiaries enrolled in a Medicare Prescription Drug plan or a MedicareAdvantage plan (with respect to qualified prescription drug coverage), the Administrator shall adjust the requirements or payments under such a contract to eliminate such excess.

''(f) TWO-YEAR CONTRACTS.—A contract approved under this section for a Medicare Prescription Drug plan shall be for a 2-year period.

''(g) IMPLEMENTATION OF PART D.—Notwithstanding any other provision of this part or part C, the Secretary shall implement, and make benefits available under, this part as soon as practicable after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, but in no case later than January 1, 2006. The Secretary shall carry out this part until the Administrator is appointed and able to carry out this part.

On page 134, strike line 9 and insert the following:

under paragraph (1).

''(d) SPECIAL RULES FOR STATE PHARMACEUTICAL ASSISTANCE PROGRAMS.—

''(1) IN GENERAL.—Notwithstanding any other provision of this part, in the case of the sponsor of a State pharmaceutical assistance program that seeks to offer a Medicare Prescription Drug plan under this part, the following special rules apply:

''(A) WAIVER OF LICENSURE.—Section 1860D–7(a)(1) shall not apply.

''(B) PERMITTING LIMITATION ON ENROLLMENT.—The sponsor may restrict eligibility to enroll in the plan to those low-income individuals who qualify (or meet the standards for qualification) for the State pharmaceutical assistance program.

''(C) OTHER REQUIREMENTS.—The Administrator may waive such other requirements of this part as the Administrator finds appropriate to promote the role of State pharmaceutical assistance programs under this part.

''(2) DEFINITION.—For purposes of this part, the term 'State pharmaceutical assistance program' means a program, in operation as of the date of enactment of this title, that is sponsored or underwritten by a State, that was established pursuant to a waiver under section 1115 or otherwise, and that provides financial assistance with out-of-pocket expenses with respect to covered outpatient drugs for individuals in the State who meet income-related qualifications specified under such program.

''(3) CONSTRUCTION.—Nothing in this subsection shall affect the provisions of subsection (b).''.

At the end of title VI, add the following:

SEC. ___. NEED FOR RENEWAL.

(a) IN GENERAL.—Notwithstanding any other provision of law, the provisions of, and amendments made by, this Act shall remain in effect but shall be superseded by the Director of the Office of Management and Budget on the date that the total of the increased Federal expenditures by reason of such amendments and provisions has reached $400,000,000,000.

(b) APPLICATION.—Any provision of law amended or effected by this Act shall be applied and administered after the date described in subsection (a) as if the provisions of, and amendments made by, this Act had never been enacted.

(c) NOTIFICATION.—The Director of the Office of Management and Budget shall notify Congress 6 months prior to the date that the provisions of, and amendments made by, this Act will be superseded pursuant to subsection (a).

Mr. DURBIN. I thank the Senator from Iowa and my colleagues.

Mr. REID. Before the Senator yields the floor, would the Senator yield for a question?

Mr. DURBIN. Yes.

Mr. REID. This is a little off point, but we are talking about jobs. Is the Senator from Illinois aware that the Bureau of Labor Statistics issued its latest unemployment figures today?

Mr. DURBIN. I did not see those.

Mr. REID. Would the Senator be surprised that under this administration, which is always talking about what a great job they are doing with the economy, we now have the highest unemployment rate in 106 months; it has jumped up now to over 6 percent? Is the Senator surprised at that number?

Mr. DURBIN. I wish I was, but we have lost 2 million jobs under this administration already. So it is no surprise we continue to lose jobs in America. I am sure it is tough in Nevada. It is tough in Illinois. We have lost good paying jobs. I run into a lot of people who, frankly, have no place to turn in this economy.

Mr. REID. Highest unemployment in 106 months.

Mr. DURBIN. I would just suggest to the Senator from Nevada, it is curious to me that the President, with his tax cut program for stimulating the economy, had his first chance at it. The Senator can refresh my memory. Two years ago didn't we cut taxes, as the President suggested, primarily for the higher income individuals?

Mr. REID. For job creation.

Mr. DURBIN. Wasn't that about $1 trillion or more in tax cuts we were proposing for job creation?

Mr. REID. I would respond to my friend, if the last tax cut we had creates as many jobs as the first tax cut, we are in big trouble.

Mr. DURBIN. I would say there is that old adage that once you are in a hole, the first thing you do is stop digging. If I am not mistaken, didn't this administration come back and want to dig that tax cut hole deeper within the last few months, and still we see these job statistics telling us this is a failed economic policy?

Mr. REID. My friend is right. The Bureau of Labor Statistics found that national unemployment had increased in April to more than 6 percent, highest unemployment in 106 months.

Mr. DURBIN. I would like to ask the Senator from Nevada, was he aware of the fact we are now proposing the creation of jobs in Iraq, and some people have said we are going to create jobs where frankly we will give money to the people of Iraq, but they don't to have show up for work for a while? That might go over pretty well in my State if we would like to create a program like that. But I would like to ask

the Senator, we are talking about the fact that this President took over after the economy had grown at a record pace for 7 or 8 years under first his father and then under President Clinton.

Mr. REID. I respond to my friend there is some dispute as to what the 10-year surplus was when he took office. Some say $7.1 trillion. Some say 6.2. But trillions of dollars over 10 years. And in fact, the last 3 years of the Clinton administration we had been spending less money than we were taking in. We were retiring the debt. But we are not worried about that anymore. We will have this year, some say, a debt as much as $600 billion, of course, not counting the Social Security surpluses which are used to disguise this. So I don't know where all this great economy is. It is not in Nevada.

Mr. DURBIN. I ask the Senator, would that $600 billion debt, if that is what we end up with, would that break the record under the Reagan administration which I believe was in the hundred billion dollar range?

Mr. REID. The debt this year will be the largest in the history of the world, not only the United States.

Mr. DURBIN. I would like to ask the Senator from Nevada, a lot of the fiscal conservative Republicans used to say you had to have fiscal discipline, get your house in order. Is he hearing the same thing I am hearing from those same fiscal conservative Republicans now, that deficits don't count, debt doesn't count?

Mr. REID. We not only have statements that would fill volumes about how bad the deficit was. And, in fact, I can remember Alan Greenspan telling us the most important thing we could do—he appeared before the Appropriations Committee—was get rid of the annual deficits. We followed his advice and did that. He is still chairman of the Federal Reserve. I wonder why he is not talking now along those same lines.

Mr. DURBIN. It is a curious thing. I recall when President Clinton was preparing to take office, that same Chairman Greenspan came to Little Rock in the transition and said: The most important thing you can do for the long-term economy is to reduce the long-term interest rates which means get serious about the deficit. President Clinton took that to heart. I think the Senator, was in the Senate, and I was in the House when President Clinton came in with his budget, which didn't get a single Republican vote in the House or the Senate. It passed in the Senate with the tie-breaking vote by Vice President Gore and then, because the Democrats stood up and did what was right for the economy, we saw this dramatic period of economic growth where people's savings were growing, retirement plans were growing, where we created some 22 million new jobs, inflation was under control, new housing starts, new businesses. And we are not talking about the deep dark recesses of American history. This was just a few years ago.

Now in 2½ years, it is amazing what this President has achieved. He has managed to lose jobs at a faster pace than any President in history and create the largest deficit in the history of the United States, all in the name of fiscal conservatism. It is really hard to imagine anyone can say with a straight face that is a conservative, disciplined approach to dealing with the budget.

I am sure in Nevada and Illinois the people don't like this economic policy and what it has meant.

Mr. REID. This is something I can't understand, why there is so much silence on the other side of the aisle about these huge annual deficits he has created, especially since when he took office we were spending less money than we were taking in. To think that the country is in such deep trouble. Does the Senator realize parts of our national parks are actually closing because of a state of disrepair, our great national parks? We have money in our highway trust fund that people pay when they go to the gas pump, but this money is not being used for highways. We are trying to come up with a highway bill, but the President is not allowing us to spend the money on highways. He wants to spend it on jobs in Iraq. I don't know what he wants to spend it on.

I didn't answer the one question the Senator asked about Iraq. Not only are they trying to create jobs in Iraq, they are now talking about paying Saddam Hussein's army for back pay while they were fighting Americans. Is the Senator aware of that?

Mr. DURBIN. I was not aware of that. I certainly want to see stability in Iraq. We all do, because otherwise it could disintegrate into another vacuum, a terrorist training ground. We don't want that to happen.

But it is curious to me, when it comes to the military cost of that war and the cost of reconstruction, there is no end in sight. It doesn't seem to bother people from the administration to continue to call for billions of dollars for this purpose.

But I would like to ask the Senator from Nevada this. He was serving here, as I was, when this President came in with something called No Child Left Behind, where we were going to send money to the schools across America for accountability and testing and upgrading of teacher skills. If I am not mistaken, this President had a White House bill signing ceremony, with Democrats and Republicans all applauding his No Child Left Behind. Yet when we look at the budget that was sent to us by this President, he is not providing the resources that we know will be needed for these schools. The Senator's State, I think, may be leading the Nation in the growth of school enrollment. In my State, we are struggling with our own deficit and cutbacks of State assistance to school districts.

So here we have President Bush's new mandates in No Child Left Behind, with no money to pay for them, while the local sources of revenue, from State sources and local property taxes, cannot keep up with demand. So what the President has done by saying we are going to focus this money on other things and tax cuts is shortchange education.

Mr. REID. Mr. President, I spoke to our State legislature and I said the President's No Child Left Behind Act is leaving lots of children behind. There was a little criticism for my having said that. But I was right.

In the State of Nevada, as we speak, the Clark County School District, which is the fifth largest school district in America, is talking about cutting back the school week to 4 days. Some of the good programs, such as the athletic programs, which I believe in, and programs dealing with the band and drama they are talking about eliminating, and they are talking about doing away with the programs for the academically talented. In fact, unless the legislature can get some resources from the State of Nevada—they don't expect anything from the Federal Government—the Clark County School District is talking about stopping all-year-around school. We have a year-round school district. They have been talking about closing schools. Well, talk about leaving some kids behind; that is it.

Mr. DURBIN. I don't think many Americans would argue that our children are overeducated. I know the State of Oregon closed their schools earlier this year, and the idea that we would eliminate part of the school year, afterschool programs, and summer school programs, to me, means these young people are not going to be given the chance they need to improve themselves.

I know the Senator from Nevada, probably more than anybody in this Chamber, has focused on the dropout issue. If we don't really have a sensitivity to the number of kids dropping out, we should not be surprised at what is happening to them. They end up with lives that are not as productive as they could be, and sometimes they end up in tragedy. If you are going to cut back on the school year, a child who really needs a helping hand to be a good student is more likely to be discouraged and less likely to be educated. How can that be good for our Nation? I know the Senator has focused on the dropout rate in the past.

Mr. REID. Senator BINGAMAN and I worked for a number of years to try to create within the Department of Education an education czar because children who drop out of school are never what they could be. We have so many students dropping out of school, and it is a shame. Those children who drop out of school will be relegated to menial work for the rest of their lives—if they are fortunate to be able to have any kind of work.

So the afterschool programs, which the Senator from Illinois and Senator

BOXER have worked on for years, are programs that, in most States, they are not even considering anymore.

Mr. DURBIN. Is it unfair, then, to bring this together and say if we are going to see this President continue to put unfunded mandates on schools and not put the Federal dollars into education, and we are going to see education cut back at the State and local level, that is going to lessen the opportunity for children to pick up the skills and education they want? This is no way to deal with an unemployment problem. Frankly, it is a way to guarantee that that problem is going to become chronic and long term because we are not investing in making young people productive and educated.

So the No Child Left Behind program and the unfunded mandate by the Bush White House really was lost to this whole argument about tax cuts. The President says we need tax cuts for jobs and growth. It just hasn't worked. As the Senator from Nevada reported today—I forget the number—it has been over 100 months since we have had such high unemployment.

Mr. REID. It has been 106 months.

Mr. DURBIN. So that is somewhere a little less than 9 years to go back to a period of time with the unemployment that high. It doesn't appear that the President's first tax cut has kicked in. If it has, it kicked a lot of people out of work. We ought to think long and hard about whether we continue down this path.

Mr. REID. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. FITZGERALD). The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that at 11 a.m. on Tuesday, June 24, the Senate proceed to a vote in relation to the Rockefeller amendment No. 976, provided that immediately following that vote and 2 minutes of debate equally divided, the Senate then proceed to vote in relation to the Bingaman amendment No. 984; further, at 2:15 there be 10 minutes equally divided prior to the vote in relation to the Dodd amendment No. 969, with no second-degree amendments in order to the above mentioned amendments prior to the vote.

The PRESIDING OFFICER. Without objection, it is so ordered.

MORNING BUSINESS

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the Senate proceed to a period for morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

ADDITIONAL STATEMENTS

TRIBUTE TO BEVERLY RICHARDSON

● Mr. BUNNING. Mr. President, I rise today to pay tribute to Mrs. Beverly Richardson of Hancock County, KY, for her legacy of service to others. Her contributions to our Commonwealth as director of the Hancock County Career Center have made all the difference in the lives of countless Kentuckians.

In 1997, when the Hancock County Career Center was initially established, Beverly Richardson, who is a proud Western Kentucky University graduate, took on the role as director, enabling her the opportunity to shape the lives of many unemployed individuals who are now working. Throughout her tenure as director, she has improved the lives of a variety of people from high school dropouts seeking to earn a general education degree, to unemployed workers in need of greater job skills to increase their competitiveness in the job market. The values and beliefs Beverly brought to the Hancock County Career Center aided her in facing the challenges she met and the opportunities each day brought as a coordinator of the center's activities.

While assisting Kentucky residents in gaining more job skills and greater confidence was a wonderful accomplishment in her life, no achievement was more notable than that of raising her four children with her husband Wendell. Together, they raised four college graduates who have paved career paths of their own and given her and Wendell many grandchildren.

Beverly Richardson's devotion to education and job training has improved the vitality of Kentucky's economy, enhanced the capabilities of so many workers, and strengthened the character of individuals and families. Employers and employees alike throughout Kentucky owe her a debt of gratitude. Her example should be emulated across America. I thank the Senate for allowing me to recognize Ruth and voice her praises. She is Kentucky at its finest.●

LOCAL LAW ENFORCEMENT ACT OF 2003

● Mr. SMITH. Mr. President, I rise today to speak about the need for hate crimes legislation. On May 1, 2003, Senator KENNEDY and I introduced the Local Law Enforcement Act, a bill that would add new categories to current hate crimes law, sending a signal that violence of any kind is unacceptable in our society.

I would like to describe a terrible crime that occurred at Fort Campbell, KY. A little after 3 in the morning on July 5, 1999, PFC Barry L. Winchell was forced outside his barracks where he was stationed and brutally beaten with a baseball bat by another Army private. Winchell died of his injuries the following day. Army officials and sources close to Winchell believe that his death was motivated by antigay bias.

I believe Government's first duty is to defend its citizens, to defend them against the harms that come out of hate. The Local Law Enforcement Enhancement Act is a symbol that can become substance. I believe that by passing this legislation and changing current law, we can change hearts and minds as well.●

HONORING FRANK A DUBOIS

● Mr. DOMENICI. Mr. President, I rise before you today to pay respect and to commend the accomplishments of a great New Mexican.

Frank A. DuBois has given the past 30 years of his life serving the agricultural producers and citizens of New Mexico. His vision and philanthropic attitude is clear when looking back to the deeds accomplished by this great man.

On June 1st, Mr. DuBois retired from his position as director of the New Mexico Department of Agriculture after 15 years. During this time, Mr. DuBois also served as cabinet secretary for four Governors. Throughout his tenure with the New Mexico Department of Agriculture, Frank worked as a field inspector, agricultural policy specialist, assistant director and, finally, director.

In addition to these great accomplishments, Frank also worked as my legislative assistant and then went on to serve as the Deputy Secretary for Land and Water Resources with the U.S. Department of the Interior.

Frank has also dedicated a large part of his life to the rodeo. In fall 2000, Frank set up the Dubois Rodeo Scholarship to help aspiring rodeo athletes at New Mexico State University. To date, 18 students from NMSU have received financial aid to help them focus more on school and their rodeo activities, rather than having to worry about meeting the financial burdens of college life.

The most amazing aspect of Frank DuBois is that for the past 13 years, he has been living with multiple sclerosis. And yet this debilitating disease has not stopped Frank from accomplishing so much. In December 2000, Frank received the DreamMaker Award from the Going the Distance for MS Research Foundation. He was diagnosed with MS in 1990 but has not wavered in his dedication to the people he serves.

Frank's life should be an inspiration to us all. Even living with MS, Frank refuses to give in. He has received six prestigious awards for his unwavering dedication to New Mexico since 1995.

I could not stand here and talk about Frank without also honoring his loving wife Sharon, who has been on my staff for many years in my Las Cruces office. Sharon has stood beside her husband through the toughest of times. She has devoted her love and time to help Frank realize his dreams and